

APPENDIX K: FOCUSED ROUNDTABLE SUMMARIES

Focused Roundtable for Providers

April 29, 1997
9 a.m. - 12 noon

Scott Daniels, Ph.D., Assistant Commissioner for Health Policy, welcomed all of the Roundtable participants. He gave a brief overview of the Bill 2785, which has required the Commissioner of Health to submit by October 1, 1997 a study of the quality of care provided by managed care in Virginia. The Study Group is charged with exploring and recommending options for creating greater collaboration among state agencies to ensure quality care and for creating effective pathways for complaints and problem resolution, such as a consumer hotline. He identified the theme for the study as “*What is the role of the Commonwealth in managed care and ensuring quality of care?*” In addition, he informed the providers participating that the Commissioner of Health had selected agencies from the state government and private sector to form a study group to explore the problems and propose options for their resolution (hereinafter referred to as the Study Group.)

Dr. Daniels said the purpose for the Roundtable is to enable the Study Group to learn about providers’ concerns and their suggestions for ways in which the quality of care can be improved. He drew everyone’s attention to the definition of “Quality” before them. He acknowledged that the word “Quality” is very difficult to define and that the Study Group, which needs to complete its substantive study by September, could easily spend the entire four months simply debating the definition of “quality.” In 1989 the Institute of Medicine conducted a study in which it looked at over 100 definitions of the word “quality,” and ultimately created its own definition. Rather than spending time on this difficult issue, the Study Group looked for a definition of “quality” that has meaning and continuity with the Virginia experience. The working definition selected by the Study Group is that developed by the Virginia State Medical Facilities Plan.

Definition (from Virginia State Medical Facilities Plan)

“Quality of care” means the degree to which services provided are properly matched to the needs of the population, are technically correct, and achieve beneficial impact. Quality of care can include considerations of the appropriateness of physical resources, the process of producing and delivering services, and the outcomes of services on health status, the environment, and/or behavior.”

During an August 1996 Roundtable meeting with the Commissioner of Health, the participants representing a diversity of stakeholders agreed that the following seven components of quality were appropriate for state oversight. The Study Group adopted these consensus components as a means to narrow the focus of the definition. The Study Group would be interested in learning what these components mean to providers in the context of their practices.

Seven Consensus Components of Quality (from August 1996 Roundtable):

1. Prevention

2. Complaint Resolution
3. Access and Availability
4. Credentialing
5. Consumer Satisfaction
6. Improvement of Community Health
7. Outcome Measures

Dr. Daniels then introduced the Roundtable facilitator, Frank Dukes, Ph.D., of the Institute for Environmental Negotiation at UVA. Dr. Dukes welcomed all of the participants and characterized the Roundtable as an informal opportunity for members of the provider community to talk with members of the Study Group. He noted that this was the first of three such Roundtables to be held, and that there would be additional opportunity in September to discuss the issues and look at the Study Group's draft report and recommendations. He reviewed the agenda and expressed the hope that everyone would have an opportunity to participate in the discussion, would speak with candor, and that the Study Group members should feel free to ask questions of the providers at any time during the meeting. He asked each participant to introduce themselves with their name and organization. [A list of participants is attached as Appendix A.]

The 7 Components of the Definition of "Quality"

The Roundtable participants were asked, *"What do these seven components mean to you as providers, in the context of your practices?"* The following is a summary of the major comments by Roundtable participants.

Outcome Measures (Component 7)

A number of participants said that outcome measures (Component 7) would be the most important criteria in determining quality. While all of the components are intertwined, quality affects patient outcomes most obviously.

The Dental Association representative said that the House Bill is directed at trying to assess delivery systems. As such, outcome data and measures are really the key to that assessment. He noted that 69.3% of dentistry is prevention. Prevention is costly and, in dentistry, may not save dollars, as compared with prenatal care. However, the outcomes of lack of prevention (such as loss of teeth) can and should be measured.

Community Health (Component 6)

Improvement of community health (Component 6) was endorsed by the Academy of Family Physicians representative as the highest priority. The Board of Health representative said it would be important to define the population base for community health; is community health defined by enrollees, the community at large, including the unserved or underserved population? What can be done to assure that these people have coverage?

Dr. Daniels noted that there is no exhaustive definition created with regard to community health. In listing

community health as a component of “quality,” the Study Group was thinking about impact of delivery systems on the community at large. The Study Group was not specifically attempting to address the indigent issue.

One participant said that even if the study doesn’t address the broader community, it is an issue that deserves attention. While the HMO’s main focus is enrollees, some things they do can affect the larger community, such as education and prevention. The question is, who is really accountable for the larger community.

Another participant said that if the State is going to measure accessibility of health care, then it will have to look at larger community. The Study Group might want to focus on the impact of insurance on the community at large; whether it be an HMO or other managed care plan, it can impact what percentage of population remains that still needs care.

Continuity of Care

Continuity of care should be added as a component, because it has become an increasingly important issue as consumers switch jobs, move, or employers switch plans. Continuity of care is especially critical for some diseases.

Prevention (Component 1)

Prevention needs to be defined, because it can mean different things in different contexts. There needs to be a baseline understanding of this term and standards for preventive care. In the context of Durable Medical Equipment (DME), prevention enters into the picture at the time of diagnosis. To an emergency physician, however, education of proper use (e.g., safety seats, seat belts, poison, etc.) is the primary meaning of prevention. To the Board of Health, population-based prevention and looking at overall trends is important.

Survey Parameters

It is very important to determine *who* is measuring the quality. If it’s the patient, the measures might be subjective. If it is some other group, the study might be more quantitative and statistical. It would be important to incorporate both types of measures, subjective and quantitative, so that the study is balanced. A number of participants underscored the importance of having a balanced survey, including measures of insurers, providers, and patients, and that one group should not be given more weight than another. It is especially important to survey the patients. Some care should also be given to which types of patients to survey. Right now, studies are determined by who is funding the study, which can skew the study results.

Access and Availability

One speaker noted that while outcome measures are, obviously, the bottom line, access and availability is the main issue in ensuring quality care. Most of the anecdotes heard about problems with managed care are from people who are sick and who have to use the HMO extensively. A person who is well, and may or may

not be working on prevention, is not likely to complain. Those who need access to care are the people who are experiencing problems. So access is the main problem.

Access is a hot issue in other ways. Access of patients to providers is a key issue, particularly in areas that are rapidly growing. HMO law has a clause that states that HMOs must have a reasonable mix of providers. HMOs say, "Our panels are full, we don't need anyone else in your area." That is their justification for keeping a provider out. Then seven new neighborhoods are built, but no providers are available to service these people. So the restrictions on panels create a major problem; the plan limits the availability of providers who can actually provide the kinds of services that the plan says will be made available.

An additional issue of access and availability is the problem created by third party payers limiting the range of services that providers can make available to the consumer. For example, physicians have the capability of performing at a lower cost and greater convenience to the consumer a number of procedures in their office which previously were only available in hospitals. Yet physicians are often unable to make these procedures available to the consumer. It is up to third party payers to make the services available through local providers.

Optometry has full prescribing privileges for eye disease. However, optometrists have found that HMOs allow them to see patients only for vision care, which means that the patients have to be sent elsewhere for medical care rather than being served more quickly and at less cost in the optometrist's office. Optometrists then have to go through a big rigmarole to get their patients referred in a timely manner for appropriate care.

Q: Is this an issue of convenience? Or does this actually impact the services patients are receiving?

A: If the medical conditions can sustain a delay in treatment, then the service provided is okay. But if there are conditions that need immediate treatment, then the quality of care suffers. There is also an issue of cost of care; optometrists might be able to provide it at less cost.

Several people concurred that convenience is an issue that very much affects access and quality of care. Some patients might not be able to easily get to some providers. Who is included on panels does not always take into consideration the needs of the elderly, disabled, or geographic issues. People have to take time out from work to obtain medical care. So roadblocks to receiving care often means that people don't get the care they need.

Access and availability also means both access to both primary care physicians and specialty physicians. For example, one pregnant woman had to travel more than 100 miles to get a test done, because the plan didn't allow for a closer provider. In the field of plastic surgery, most HMOs exclude reconstruction due to trauma that did not occur while the patient was covered. There are congenital defects (harelip, back, other problems) which are therefore not covered.

Medically Necessary

The Physical Therapy Association representative said that the insurance company determines what is medically necessary, which causes many problems. For example, a physical therapist cannot do any therapy without a diagnosis code. In the case of a 2-year old rheumatoid arthritic patient, the company doesn't want to provide therapy because surgery might be needed in a few years. Other therapies have a limitation of 90-days; this limitation doesn't work for chronic problems. Also, physical therapists are treating more complicated pediatric cases and cross-training in physical therapy is becoming expected.

The Virginia Dental Association said that the phrase "medically necessary" is a problematic euphemism. For example, one plan says that oral surgeons cannot do reconstructive surgery on a face if the person can maintain weight with liquids. It is one thing to say a treatment is not covered by the contract, and that it is a contractual issue. It is another thing to say the treatment is not "medically necessary," when in fact treatment is appropriate and acceptable but is simply not being referred and delivered.

We need to change our language. We need to determine whether a treatment, first, is appropriate or not appropriate. If it is appropriate, then it is either covered or not covered. It is misleading to talk about the medically necessary or unnecessary.

Q: In the case mentioned, what happens to the patient? Is there a complaint system?

A: What the physician must do, to make sure the patient receives the appropriate treatment, is to become hyperbolic. You have to exaggerate problems to the Nth degree to get the patient covered. The issue of having a consultant determining whether something is medically necessary is nothing but a smokescreen!

It is interesting how the discussion has moved from a definition of quality care for communities to individuals. This is important, because the problem with our current system is how it fails to meet the needs of individuals for whom discussions of the aggregate just don't work.

The issue of determining what is medically necessary means that judgment must be applied at some point. Today, the struggle is to determine the locus of that decision-making. Should the decision lie with the legislature, with HMOs, with individual providers (where it used to be), with a nurse over an 800-line, with someone who has an adversarial role toward the patient, or a group of local care physicians who are closer to the patient and will develop a "care protocol" for the patient? The speaker hoped for the latter. Just because we have a fair degree of comfort with the current system doesn't mean it is the best.

Judgment is needed in determining whether a treatment is medically appropriate. Then, if it is medically appropriate, other people can decide whether contractually it's covered or not. There is a huge difference between saying something is medically appropriate but is not covered, and saying that some third party has determined it is not medically necessary.

Timely Access

Timely access is an issue. Pharmacists have a problem in both acute and chronic situations where they may

be required by formularies to change medications that have been ordered. It can take a long time to contact the physician or HMO to obtain their concurrence, sometimes as much as a one or two day delay in delivery of the medication to the patient.

Q: Is this a problem with just HMOs or managed care in general?

A: Managed care. More Pharmacy Benefits Managers (PBMs) are being used to manage prescriptions, but there are no federal or state statutes that establish oversight of PBMs. We are being asked by PBMs to make decisions on a monetary basis, not a professional basis. This is an infringement on our professional conduct.

Sometimes a switch in medication is made without the provider knowing about it. Other times the physician is called by the HMO or PBM, and asked to make a switch, regardless of the local pharmacist's recommendation. Sometimes the pharmacist can block a change, but often is not able to. This is clearly a case where the cost savings are for the HMO, not for the patient.

Q: Is the PBM a risk-bearing entity?

A: No. Some of the materials sent by the HMO to patients contains innuendoes about what is appropriate or not appropriate in terms of care. There should be some kind of mechanism for complaints by providers, to enable challenges to the HMOs' determination of what is medically appropriate.

The HMO does not always follow the latest research or recommendations on what is the best care, and there should be an established mechanism or path to challenge the HMOs on this.

Q: Did you say a drug could be switched without the pharmacist's knowledge?

A: (Physician answering) Yes. Calls for a change in drug can come directly from an HMO to the physician.

Q: So the physician makes the decision?

A: Not always. Sometimes patients will come back for a second visit with drugs that are close but not the same as that prescribed. On checking, we find that the pharmacist didn't know that the drug prescription had been changed. The medicine may be considered "pharmaceutically equivalent," but in reality, given that the patient may have a variety of conditions and drugs which need to be managed and monitored carefully to avoid complications and interactions, the drug is not exactly the same.

For example, one patient had been put on a drug that worked well. The patient switched to another

HMO, which didn't allow this drug because of the cost. So the patient was switched by the HMO to another similar, but different, drug, to which s/he had a terrible allergic reaction and is now taking Prednisone for that reaction.

Another example is of a complaint received regarding a patient who was told that a drug was no longer available to her, when in fact it was available, and at a dosage that would have been cheaper for the patient. A number of questions arose from this complaint: Why was the patient's social security number divulged in a letter? Why wasn't the cheaper drug given? Why was the patient not told the drug was still available? Where was the physician in all of this?

Patient Confidentiality

Patient confidentiality is a very real concern. Pharmacists transmit to the HMO all information regarding drugs, patients and physicians. Companies can track a physician's prescribing history because pharmacists use tracking numbers. So all of this information is in the hands of the HMO, which gives the HMO a great deal of power. The question is, are they really respecting the confidentiality of patients?

There are lots of roadblocks to doing what is right. Research may support a particular treatment modality, but access to that treatment can be limited by HMOs. To do what is right, you have to create hyperboles and play games to get around the roadblocks. Sometimes it works, sometimes it doesn't.

Q: Do you have access to a medical director to talk about appropriate care?

A: A number of speakers responded that this issue was problematic. Sometimes the medical director has no background in the medical specialty or is not familiar with the recent research. Sometimes the name of the medical director is not allowed to be given. Sometimes access is only available to case managers, and often they have no medical background, no nursing background, no background in science, and even no college degree. Sometimes they just have a high school diploma. This can be very frustrating as a lot of time is then spent explaining the issues, all while the patient is waiting for an answer. Sometimes, the person says they will get you an answer in a couple of days, but the patient is standing there needing an answer now. Because of this system, providers have to become "cheerleaders" and "pushers" to get the care provided to patients.

Denial of Coverage/ Denial of Care

Q: I'm hearing today that care is being denied. However, we hear from HMOs that care is not being denied, only coverage is denied. Can you speak to this? Is this a problem inherent in the system, when you place financial risk and medical coverage in the same entity?

A: A number of people, in responding, indicated that a denial of coverage can be tantamount to a denial of care when the patient has no other resources with which to obtain the care. A Fortune 500 CEO, for example, can afford to pay for a treatment that is not covered by a plan and, therefore, there is

no denial of care. For someone else, who cannot afford to pay for the treatment out of pocket, the denial of coverage means that the care effectively is denied.

An additional difficulty is that those who are making decisions are not accountable to their individual Boards for the decisions made; thus the public has no protections from decisions made about medical necessity.

It is not really new for risk and coverage to be housed in the same entity. Insurance companies have been doing this for a long time. They insure against unforeseen circumstances and make decisions about coverage. Medicare operates this way. Under managed care, much more utilization review goes on than in other types of insurance companies. The only way to get around this issue is to have a fully socialized medicine which, of course, could be part of this debate.

A lot of the problem of housing coverage and risk together could be addressed by establishing a set of checks and balances.

Utilization Review Statute

Q: Is the Virginia utilization review statute used? Does it work?

A: For Durable Medical Equipment, patients are not generally aware of how to use the utilization review process. We tried to go through a Chapter 54 review but were told that DME wasn't covered and, in the case of an antibiotic, told it wasn't on the formulary. Some HMOs have processes in place to handle situations, whereas others don't. In this situation there was no process to go outside of these bounds. The patient either had to pay over \$100 for the antibiotic on their own, or not get the drug. A physician made the determination that he did not want to change the prescription. So it was up to me to try to help the patient. Providers are put in the middle and have to expend huge amounts of time to try to resolve the problem for their patient. Yet, this is uncompensated time that providers spend on the patients.

The bigger question is whether the development of formularies is covered under the utilization review statute. Does the formulary have to be developed in accordance with the statute ["objective, clinically valid, and compatible with established principles of health care ... and sufficiently flexible to allow deviations from norms when justified on case-by-case bases"]?

Q: What steps have been taken to educate consumers and providers about the Statute?

A: The Medical Society publicized the statute in its newsletter. The Dental Association publicized the passage of law, but not more. Some responded that they cannot remember receiving any information from the Academy of Family Physicians. Several people commented that education is very important, and is everyone's responsibility.

Q: Does VDH have guidelines for procedures? Has the Bureau of Insurance defined procedures that would implement Chapter 54?

A: The Bureau of Insurance has a record-keeping requirement, and conducts reviews to assure compliance with the policy, but the major frustration is that it has received no inquiry from anyone who has tried or wanted to use the statute.

Q: Why is this?

A: One person responded that patients do not know about their right of appeal, and they don't know how to use the process. In one case, however, when a patient did try to use the process, the patient felt overwhelmed by the process and felt she had to hire a lawyer to file the appeal. That should not be the case. The HMO should provide a copy of the protocols to the providers when requested.

Q: Has anyone requested the protocols?

A: A physician responded that, yes, he had requested the protocols and received them by fax the same afternoon. However, he doubted that people not on the clinical side could understand all the language involved in the protocols.

A DME representative responded that she could not obtain lists of either the covered drugs or of pharmacy protocols, and that they were very difficult to obtain.

An HMO representative said that HMO newsletters do publicize protocols, but acknowledged that language used in the protocols may be difficult to understand.

Regarding prescription forms, the HMO assumed that another entity would have contacted *all* providers who write prescriptions to notify them of the imminent change in prescription forms, to come into force on July 1. Virtually nobody will be in compliance on July 1. One of the

reasons for this problem is that the law did not specify how or who would be in charge of implementing the law.

The representative for the Department of Health Professions said that, historically, insurers have been in charge of implementing changes. However, the view of that responsibility is changing around the nation.

Accountability

Various people made comments about accountability. One provider said that nowhere in the philosophy of

HMOs are HMOs held responsible and accountable. Providers are held responsible, but not HMOs. HMOs are making medical decisions and therefore should be held accountable. Providers are held accountable for providing quality care by the patients, when in fact the decision makers are the payers or the HMOs.

The Department of Health Professions speaker said that, in Virginia, the question is still unsettled as to who should be accountable. Functionally, if someone is making a decision that affects care, then they are practicing health care and they should be held accountable. The questions of who should be accountable for licensing the decision-makers, who is functionally practicing, and how there should be mechanisms for accountability, are not yet answered. The Department of Health Professions gets complaints about this issue from physicians in Virginia, as well as complaints from physicians in other states about decisions that were made in Virginia which affected a patient's care in another state.

A Dental Association representative mentioned what is known as a "gag" rule, whereby the provider is not allowed to inform the patient of all of the medical options that should be considered in their treatment [Note: HB 1393 prohibits this practice]. He suggested that State Boards should be more pro-active about dealing with the contractual issues and language in provider agreements, such as not being able to discuss all medical options.

The Physical Therapy Association representative mentioned a recent case of a federal employee in Northern Virginia who went to her PCP to get a prescription for physical therapy. The physician started to write out the prescription, and the patient said she wanted to use the "point of service" option. The physician said he could not do that because he would lose a "bonus" from the HMO. The PT found this difficult to believe and checked with the managed care organization, which confirmed that the issue of the bonus was true.

Boards need to hold the providers accountable for these kinds of decisions.

This situation creates a double bind. Providers are faced with a terrible dilemma of either not signing a managed care contract, and thereby losing, say, 70% of their patient base, or signing a contract and thereby dying slowly because they won't be able to provide the standard of care that they feel is appropriate. The wrong entity is being punished.

Dr. Daniels commented that the point of the mandated study is to deal with what is possible to accomplish, and what can be changed in the managed care system. The Study Group wants to help monitor the quality of managed care and stay away from punitive measures.

One person said that a problem created by shorter contracts is a lack of continuity in care and accountability, as well as an understanding of what it going on for the patient. An option to improve this situation would be for plans to establish contracts to providers for three to five years, to ensure better continuity of care and accountability.

Home health care accounts for less than 3% of managed care. A problem for home health care is that the number of authorized visits are limited. Often home health care providers are forced to discharge the patient

before the patient's treatment is completed.

What Works, and What Is Needed?

In terms of what is working now, HMO enrollees will be given a phone number for complaints, and providers hopefully also have this number, which enable them to follow up with complaints. The phone number will be on the enrollees policy, and questions regarding quality of care will be funneled to the Center for Quality Health Care Services and Consumer Protection in VDH. Also, pharmacists are required to post the phone number for the Department of Health Professions.

The Virginia Hospital and Health Care Association representative said that some general education about the new statute would be worthwhile, and offered resources from her organization to help make it happen. She also noted that the percentage of the population affected by insured plans providing managed care is only 25% of the population in Virginia. The Study Group cannot address Medicare or ERISA. It is important to be realistic about how far-reaching these changes will or will not be.

One participant stressed the important of creating a position for someone who will help consumers navigate through the managed care plans. This person should act as an ombudsman rather than an arbitrator, and should help consumers regardless of whether they are covered by ERISA, Medicare, or a managed care plan. To be able to resolve complaints and understand the system should not require the threat of court action; it should just take "two reasonable people" to sort through the options.

Q: Should this kind of assistance be provided at the state level? Or should it be offered internally, within the plan?

A: The HMO representative said that there are customer representatives currently employed by plans. Sometimes these people can answer basic questions, but with more difficult questions someone else will usually need to provide assistance. If the issue is coverage, then more is at stake than "navigation" which can be considered simply an administrative problem. The hope is that by formalizing access to a third party through promulgation of the phone number, people will obtain the assistance they need.

Q: Let's say that a person covered by ERISA with a complaint makes a call to the VDH Center for Quality Health Care Services and Consumer Protection. What happens?

A: Complainants would first be referred to their Employee Benefits Manager, and ultimately could be referred to the Department of Labor.

The HMO representative said that, hopefully, the person would go to his/her employer first. Also, HMOs are required to have an internal grievance process.

Q: If I am fully insured, subject to state law, what can the VDH Center for Quality Health do for me?

A: That would depend on the nature of the complaint. The Center would listen to you, and would first ask if you had talked with your insurer. If the Center determined a quality of care issue existed, it would conduct a formal complaint investigation with the HMO and the results of the investigation and resolution would be communicated to the complainant. The Center has received very few HMO complaints to date and those they have received have been resolved favorably.

It seems like there is a need for a third person neutral who can provide real assistance. Patients who make calls to VDH often don't seem to get the help they need. Also, the issue of having internal review with the insurer raises the question of whether such a review would be unbiased, and whether there is a need for something over and above this.

There needs to be a mechanism to make sure HMOs provide sufficient information on their grievance process, how many complaints are received, and how they're resolved, because the number of complaints published make it seem like there isn't a problem.

One provider suggested that it could be helpful to come up with a uniform form for providers that states the recommended treatment, indications of treatment, and the probable effects of not following treatments, just like the kind of form used on a board exam. Such a form would take care of a great deal of problems.

Another provider suggested that the HMO coverage does not always meet current standards of acceptable care. Protocols for certain diagnoses are sometimes old, not reflecting more recent research. What can we do, how do we go about disagreeing with the general protocols?

Q: Is there a mechanism for providers to disagree with protocols?

A: The HMO representative said that a cookbook approach to care makes her nervous. The key would be "outcome mechanisms."

Another provider suggested the need for an appeals mechanism where providers who feel that protocols don't meet appropriate levels of care could appeal the protocol.

Concluding Comments

To conclude the meeting, each provider was asked to provide a final comment or recommendation for consideration by the Study Group.

Virginia Optometry Association: The priorities should be to ensure patient access to providers, to ensure that the HMOs follow the laws, and that providers have access to panel membership.

Old Dominion Medical Society: It appears that a segment of population is being ignored, and the question should be addressed of how you get certain segments of the population to the providers of care, whether it

be the DME, physicians, or whatever. Secondly, the issue is to make sure that everyone understands the language that is being used and their full range of options.

Virginia Hospital and Healthcare Association: We are dealing with an immature marketplace, which is reflected in the levels of insecurity, hostility, and raging hormones. What we need to do is ask the question, “How can we help this marketplace grow well?” The key is to hold people accountable for their decisions. Health plans need to be held accountable. We also need to find ways to equip small businesses with ways that they can document the performance of plans along the seven identified dimensions of “quality.”

Virginia Academy of Family Physicians: Third party payers should be able to measure requests for providers, and determine who can provide that service best. There is a notion now that if someone doesn’t fit in the system that they’re not accountable. This is not true. So third party payers should have a credentialing process to make sure that providers perform services that are within the knowledge base of that provider. For example, a provider should not be denied the opportunity be credentialed merely because of geography.

Virginia Physical Therapy Association: The major issue is access and availability. There is also a need for patient advocacy and education in managing and navigating the managed care system.

Board of Health and Nurses: Patient advocacy is essential. There is also a need to find a way to address the issues of the under and un-insured.

Hospital Home Health: Providers should not have to be advocates for patients; patients should have a way of knowing their options and be able to easily access the system on their own.

Old Dominion Medical Society, rep #2: We all need to be accountable for the health care system that develops. Today, doctors are evolving into Medical Managers, where half of their time is spent on paperwork and maneuvering through the system. The issue of quality is *passé*, an issue of 25 years ago. We need a different notion of what quality is today; for example, if I am to be accountable for management then you need to find a way to oversee and determine the quality of management provided, in addition to the quality of actual health care.

Virginia Association of Durable Medical Equipment: Accountability is the key issue. Accountability should be shared by all decision makers. The Study Group should look at educating and resolving issues for the individual patient, to make sure that the individual patient knows how to use the system, whether it be through an ombudsman or other mechanisms. Most of the problems today arise because people don’t know how to use the system.

Virginia Pharmacy Association: Accountability is the key word. Everyone, from patient to the insurer, should be held accountable for their decisions. Pharmacists are being forced to make more decisions based on policies set by HMOs. Patients and providers need to be able to have more input into the development of policies set by HMOs.

Virginia College of Emergency Physicians: In emergency cases, access and availability are not an issue. We treat everyone who comes through our doors. Two laws do affect our work: (1) the prudent lay person law - is the managed care facility the one who should decide whether the prudent lay person law applies?; and (2) the law requiring, beginning in July, that managed care will provide timely access to PCPs. The study group needs to find a way to monitor the application of that law.

Virginia Chiropractic Association: We need an independent organization to which these problems can be submitted. The organization should be staffed by a mix of providers, citizens, etc., to take a look at all of the issues such as HMO policies, the number of providers, access, protocols, etc.

Medical Society of Virginia: Quality care requires access and availability at all different levels. It also requires accountability by all persons in the process. It requires education regarding provider care, a complaint process and review, and education to providers of data on how providers can improve their practice in managed care.

Dr. Daniels and Dr. Dukes thanked everyone for participating in the Roundtable and sharing their views. A report on the Roundtable session will be posted on the website address <http://www.vdh.state.va.us> and also mailed to attendees.

Focused Roundtable for HMOs

May 6, 1997
2:30 p.m. - 4:30 p.m.

Scott Daniels, Ph.D., Assistant Commissioner for Health Policy, welcomed all of the Roundtable participants. He gave a brief overview of House Bill 2785, which requires the Commissioner of Health to submit by October 1, 1997 a study of the quality of care provided by HMOs and other forms of managed care in Virginia. The study is charged to explore and recommend options for creating greater collaboration among state agencies to ensure quality care and for creating effective pathways for complaints and problem resolution. He identified the theme for the study as “*What is the role of the Commonwealth in managed care and ensuring quality of care?*” In addition, he informed the HMOs representatives that the Commissioner of Health had selected representatives from the state government and private sector to form a Study Group to explore the problems and propose options for their resolution.

He noted that the Study Group was convening Focused Roundtables for the three groups of providers, HMOs, and consumers/purchasers so that the Study Group members could hear from and interact with these groups regarding ways in which managed care in Virginia might be improved. He expects that summaries of the Roundtables will be posted on the internet by the end of May at the website: [Http://www.vdh.state.va.us](http://www.vdh.state.va.us).

Dr. Daniels then introduced the Roundtable facilitator, Tanya Denckla, C.M., of the Institute for Environmental Negotiation at UVA. Ms. Denckla welcomed all of the participants and characterized the Roundtable as an informal opportunity for representatives of HMOs to speak with members of the Study Group. She reviewed the agenda and expressed the hope that every HMO would have an opportunity to participate in the discussion, would speak with candor, and that the Study Group members would be asking questions of the HMOs throughout the meeting. She noted that the Roundtable had a challenging agenda because they would be trying to discuss in two hours a number of important issues that are complex and technical in nature. Because of the time constraints, she encouraged all participants to keep their remarks brief and to the point. Recognizing that people would not have time to say everything that they might wish, she noted that there would be an additional opportunity in September for HMOs to discuss and comment on the Study Group’s draft report. She asked each participant to introduce themselves with their name and organization, then proceeded to describe the general outline of questions for the session. Twelve questions for the Roundtable were drafted and mailed in advance to HMO Roundtable participants. These questions are numbered below, Q1 through Q12. The questions were grouped into three subject areas to facilitate discussion: Quality Improvement, Quality Patient Care and Medical Necessity, and Quality Providers.

Reporter’s Note: Comments are attributed to representatives of the following HMOs that were invited to participate in the Roundtable. In some cases more than one representative of the same HMO may have spoken, but we have simply indicated the HMO. We have also indicated when comments have come from the Study Group or Facilitator.

Whenever possible, we have indicated the speaker where it seems important to know which organization is

speaking; in other cases some questions and comments were made that did not seem to require identification as they were generic in nature. In a few cases we could not identify the speaker because they were not clear from the tape or notes.

HMOs Represented

Aetna/ US Healthcare
Capital Care, BCBS
Chartered Health Plan
John Deere Health Care
HealthKeepers, Trigon
Kaiser Foundation Health Plan
MAMSI
NYL Health Care Plans of the Mid-Atlantic
Prudential
QualChoice of Virginia
Sentara Health Systems

Organizations Represented on the Study Group

Office of Health Policy, VDH
Center for Quality Health Care Services and Consumer Protection, VDH
Joint Commission of Health Care
Virginia Association of HMOs
Virginia Department of Health Professions
Virginia Department of Medical Assistance Services
Medical Society of Virginia
State Corporation Commission, Bureau of Insurance
Virginia Hospital and Healthcare Association
Virginia Chamber of Commerce
Virginians for Patient Choice

Quality Improvement

Q1: What are HMOs doing to ensure quality that was not being done in the traditional fee-for-service environment?

Prudential: There is a lot that we do from the outset. We credential providers who wish to join the network, which involves collecting a lot of data, and then we recredential them every two years. We also use about 60 measures to assess the plan on an annual basis. These include measures of pure clinical quality as well as service measures such as the speed of answering telephones. Many of these measures are recommended by “HEDIS” (Health Employer Data Information Set) but they also include access to providers and availability of providers. We have standards that we’ve set and communicated to providers. If we find our

standards are not met, we work with them to get them back up to where they should be.

Kaiser Foundation: We have multiple member and provider complaint processes at multiple levels. Also, we have an extensive prevention program that would not typically have been found in the traditional fee-for-service setting. Prevention includes regular scheduled exams as well as outreach about the importance of proactive and screening exams such as mammogram and children's check ups. This kind of outreach was not done by the traditional system.

Prudential: Outreach is key, because this is the way we are finally reaching people who are generally healthy and were not traditionally reached. If you look at the measured baselines of some of these impacts, you see improvement by up to 20 percent in these measurements, based on just a few years of this kind of outreach.

Chartered Health Plan: The outreach done by HMOs is not just a telephone outreach, but an in-home outreach program. We identify members who are potentially high risk, and do case management and follow up with these members.

Capital Care: In addition to outreach, we are also doing research on the general systemic barriers to care across our entire population, making some interventions, and then re-measuring to see if we've had an impact.

Aetna/US Healthcare: To judge a health care system, it is important to look at disease prevention as well as disease management and intervention. We've also developed very extensive disease management programs, where we establish protocols that are often developed in conjunction with health care agencies. The structure of the current health care system is much more comprehensive to ensure overall quality care.

QualChoice: For the first time, managed care is inviting customers for insights and feedback about their care. We are constantly asking for feedback through provider and customer surveys, to find ways in which we can improve the quality of our service.

HealthKeepers, Trigon: One difference is the consistent loops of information used by HMOs to collect data on both service and care. Particularly with regard to the provider community, this kind of information has not been readily available before; providers were not able to know trends in the marketplace, what their colleagues were doing and how they compared. This didn't happen with fee-for-service.

John Deere: The general population benefits from this too, because as providers get feedback they will improve their care to all purchasers, whether or not they are covered by our plans.

Question from Study Group member: Are the quality mechanisms migrating over into the general population, and if so to what degree?

Capital Care: The quality program extends beyond just the HMO to point of service products and, to a lesser extent, some of the credentialing. In terms of complaints and preventive programs, they extend to our general population as well.

Aetna/US Healthcare: There are different packages, some for self-insured, which are offered through and designed by plan sponsors. We've offered all of our benefit packages to plan sponsors. We have extended these programs to all our products, and this has been beneficial to all customers because it has improved outcomes. So I do think there has been some migration of products offered by managed care to the rest of the population.

NYL Care Health Plans: Some of us offer several products, but there is a natural boundary so that a number of these quality measures cannot migrate. They might be bounded by the contract; a lot of these quality issues are accomplished through contractual relationships. However, to the extent that anyone is using the services of a doctor participating in any managed care program, the quality is improving overall.

Sentara: It's much harder to demonstrate products in non-clinical programs. You can't use traditional insurance models with current patients, because they didn't have the contractual agreements back then.

Question from Study Group member: To the extent that providers are credentialed into networks, what components are involved in the credentialing process and approximately what weight is given to each component?

NYL Care Health Plans : It's hard to generalize across the plans. If you look at national statistics, it is clear that board certification is a good qualifier. We're all struggling to find markers. One of the more obvious markers that's widely accepted is board certification. Nationally, in HMOs, 80% of participating physicians are board-certified while, for the overall population of physicians, 65% are board certified. Most of us look for board certification as an indication of quality.

Aetna/US Healthcare: We also look at the doctor's use of products, type of medicine practiced, hospital privileges, whether there are any state sanctions, and we try to ascertain whether the doctor meets certain standards. We also conduct individual interviews. There are a number of ways we try to ensure that quality care is provided to our customers. This also relates to the first question because, in fee-for-service medicine, a physician only needed a license to practice.

Kaiser Foundation: Beyond the initial credentialing, we do a re-credentialing every two years in which we look at their records, complaints received, and do physician reviews, to ensure that physicians are meeting our quality care standards.

HealthKeepers, Trigon: Most of our HMOs also review the office environment in the initial credentialing and recredentialing. We look at whether they have the space, supplies, and staff to be able to handle the patients and meet the standards of HMOs quality of care.

Question from Study Group member: Is economic credentialing a part of credentialing a provider? Length of course of treatment? Average charges per course of treatment for a particular physician?

Aetna/ US Health Care: Our philosophy is "open access, open choice." We try to bring in all physicians who meet our criteria.

Prudential: We don't really have that kind of information about physicians, before they are credentialed the first time. When they are recredentialed, we do look at some of the utilization data. Are they more of the outliers? Do they have sicker patients? We frequently meet with the providers to understand the data. Often there are good reasons for these trends. We also talk with providers more than just every two years. We go out and talk to physicians, and to educate them about how their peers are doing things in a more efficient manner.

NYL Care Health Plans: The problem is that usually there is not just one variable. Usually a network of patterns is visible from doctors who are providing poor care. During reaccreditation, these should be explored and identified.

Q2: What mechanisms are available for providers to present issues and concerns regarding quality? For consumers?

John Deere: In addition to dedicated customer service lines, we provide a dedicated toll-free line for all providers to call in to ask questions. For providers, we have a local quality improvement committee that meets every other month. Local physicians serve on this committee. For our customer service lines, we have customer service representatives who have access to all information. We take walk-ins, phone calls and letters.

Aetna/ US Healthcare: The Medical Director has a credentialing committee, which is a forum for physicians to provide information to HMOs and to discuss their concerns. Medical Directors also serve the function of taking calls from providers, to determine whether there the provider's issue concerns a physician or other aspect of quality care, and to be an advocate for the physician.

MAMSI - We have a unique contractual relationship with our physicians. At MAMSI physicians are contracted with through an organization called Physicians Health Plan, Inc. which is a subsidiary of MAMSI that is totally controlled by physicians. In essence it is a physician's Board that can serve the function of receiving complaints and concerns from physicians. So physicians will not only contact the HMO Medical Director but also often contact the Board, which then brings the provider concerns to the HMO.

NYL Health Care Plans: The opportunities for feedback from providers seem almost endless. Our plan was founded by doctors. Doctors sit on our Board, on peer review, and head the credentialing committee that meets once a month. We have a segment of our customer service department that is dedicated specifically to provider concerns, plus a segment of our client relations department that is geared specifically to providers. If none of these avenues meets the doctor's concerns, they can and do call me. Doctors are not shy about pursuing the interests of their patients or their own interests.

Question from a Study Group member: In the previous provider focus group, the issue of providers' concern about retaliation or somehow being black-listed was raised several times. Can I hear some discussion of this?

MAMSI: I have an anecdote about this. There was an OB/GYN physician and oncologist in our network who, both, believed that we had denied them from aggressively pursuing some of the issues that they felt were important. Our form of "retaliation" was to invite them to participate on our Boards, which they have

accepted. They are now helping us to understand some of the issues they felt were important as well as participating in the decision making.

Capital Care: Members of the Medical Society of Virginia serve on our peer review committees. These physicians have given us very specific feedback. They have created an office environment measurement tool that we now use. They have led us to change our benefits for diabetic education. So their feedback has resulted in demonstrable changes that were needed.

Chartered Health Plan: We invite physicians to meet with us on a quarterly basis for the sole purpose of giving us a sense of how the HMO is doing, so that we can make adjustments to meet the needs of the provider.

Sentara: We have a strong relationship with the Independent Practice Association (IPA); this is a new liaison that doctors can use. As an integrated health plan, we have a unique opportunity to work with physicians not only as providers but also as our medical staff. We have a Chief Medical Officer who is Chief for both the plan and the hospitals. Our Chief Medical Officer and his staff of other physicians meets regularly with the teams of emergency physicians, cardiologists, etc., to both gather and act on their feedback. I don't think physicians have ever had more input. Two years ago the whole organization went through a major reorganization and strategic planning process, and physicians played a major role in this.

Aetna/US Healthcare: The issue is how information flows back to the HMO. A lot of that has to do with the structure of the organization. In health care, we have three basic divisions: health care delivery, operations, and marketing. Health care delivery is directed by Medical Directors, and reviewed regionally on a monthly basis and nationally on a quarterly basis. Information filters up to us, and then back down. Medical Directors act as a kind of conduit for information.

Question from Facilitator: Regarding the issue of fear of retaliation, are there mechanisms for anonymous or confidential feedback?

Prudential: As far as the retaliation issue, if a provider has a problem with what we're doing, we really want to hear and interact with that provider. The provider does not need to give information about the specific patient, but does need to give us general information that we can act on. We take patient confidentiality very seriously, and recently let two physicians go who innocently divulged information about a member, and there was no second chance. It's hard to set out a proclamation that, "we're not going to retaliate." If a physician submits a complaint, and we act on it, then that filters back to the physician community and instills a sense of confidence that there won't be retaliation.

NYL Care Health Plans: We made it very clear in our newsletter that we are very strong about our policy to encourage physicians to advocate for their patients. We just ask that physicians don't libel or slander us, but it is okay for them to file any other kind of complaint. Every single termination over the last two years has been because of concerns over quality of medical care, not because of a complaint that they made.

Question from Study Group member: It seems that the closer the provider is to the Medical Director, the better. It sounds like confidentiality is not a problem. How would you react if there were to be

a “for cause” clause in the contract?

A number of people answered that “for cause” clauses already exist. Either party can terminate contracts if they give 60 or 90 days notice. Termination “for cause” usually occurs only after a great deal of effort has been made to work with the physician. One HMO said that they would normally give a physician two to three years to try to come into line with the norms. In cases of termination “for cause,” there is a due process system to address appeals.

Study Group representative of Virginia Association of HMOs: Recent data for Virginia shows that voluntary terminations by physicians is about 2 to 4%, which is very much in line with national norms. These includes terminations for any reason, whether it be retirement, moving, or other reasons.

Question from Study Group Representative of the Bureau of Health Insurance: We receive a lot of questions and allegations from physicians indicating they are concerned about saying things for fear of retaliation. So the perception of possible retaliation, whether or not it is reality, is there. One of the purposes of this study is to make recommendations for changes in legislation or regulations. What ideas could you share as to how we might remedy this situation through a change in legislation or regulations?

Study Group Representative of the Virginia Association of HMOs: There is already legislation on the books that addresses this issue. The Utilization Review Statute, Chapter 54 of title 38.2-5400, adopted two years ago, prohibits the HMO from retaliating against providers for advocating on behalf of the patient. It is not a question of needing more legislation and regulation.

Study Group Representative of the Medical Society of Virginia: This is a major issue. We’re saying, especially to doctors in Northern Virginia, you’ve got an 800-number to call with your concerns and complaints. But they are unwilling to use that number. So the question we’re asking is, why would doctors say that they won’t use the 800-number? Because of fear of retaliation?

Sentara: Working on both the hospital and practice side, I have rarely met a physician who is reluctant to complain. Doctors are fairly vocal about their concerns. The reality doesn’t fit the paranoia. When you look at the numbers of terminations in the last few years, the data just isn’t there to justify the fear.

Question from Study Group member: So, your view is that the physicians don’t let this build internally, and that they freely bring their concerns forward?

Aetna/US Healthcare: Perhaps one big thing that could help is to inform physicians that the HMO provider turnover rate needs to be reported to our major purchasers. So if purchasers find that we have a large doctor turnover rate, that is seen as problematic for the HMO. So this is an incentive for the HMO to try to work with doctors and keep them on board. Perhaps it would be important to let doctors know how important a low turnover rate is for sales.

Capital Care: We found that our complaints were relatively small in number, but we realized that we are only as good as the information that we receive from our providers. So we formally decided to make a goal

of increasing the number of complaints. We knew there were concerns, and we needed to find a way to obtain them. We published this goal in our newsletter, and told people the process and outlet for their concerns. Since then we have seen the numbers of complaints increase, and that is exactly what we wanted in order to see what was going on for our members.

Aetna/US Healthcare: Doctors rarely complain anonymously. We employ professional service coordinators, whose function is to see each practice in our network at least three times each year. This a very important mechanism for feedback.

Prudential: These provider relations people usually focus on certain types of practices. If we get a problem over the phone lines, these people will usually be called in to deal with the issues. If it's a clinical issue, it will be brought to me. We also have member rights and responsibilities that we publish and send to members. Perhaps we should think about having physician rights and responsibilities, where they understand what their right is, yet also their responsibilities?

Study Group Representative of the Virginia Association of HMOs: It sounds like the issue is a failure to communicate. Whether or not you call it physician rights and responsibilities, the Association could craft some of the concerns, could get four or five points of what is available to physicians, and publish it so that we could get rid of this unfounded paranoia, which I hear about anecdotally. We've heard that terminations are very, very few, so it really seems the issue is communication and packaging that communication.

QualChoice: If your data, from the Medical Society, differs from ours in terms of the termination levels, please let us know. It sounds like, thus far, the low level of terminations is unrefuted. So if the termination levels are that small, the question becomes whether fear of retaliation is more a perception issue than reality.

Study Group representative of Virginians for Patient Choice: Sometimes I hear that there is an A list and B list of providers. As a patient, I can ask to use a particular provider, and the HMO can say that the provider is not available while the provider says they are in the network. This kind of experience has led people and providers to believe that there is an "A" list that receives referrals while the "B" list is those who complain. This kind of retaliation would not show up in termination data, it would be more a procedural retaliation to squeeze people out.

NYL Care Health Plans: The HMO is not so organized or sophisticated to accomplish this, even if we wanted to do it, which we wouldn't. That kind of practice hurts us in the long run. If we ignore the problems, then we will eventually lose because the physicians have a choice as to which network they wish to join. We are not so dominant that we can afford to lose our physicians. None of us is holding a gun to the head of providers, because it is in our interest to find out what is going on, what is going wrong, in the community. We don't need legislation to spell out a specific procedure for employees who are worried about the CEO. Paranoia doesn't call for changing legislation.

***Study Group Representative of the Virginia Department of Health:* Do a lot of the concerns expressed extend to non-physician providers? Do the same mechanisms and procedures apply across the board?**

Numerous people responded that, yes, the same mechanisms and procedures apply to all.

Quality Patient Care and Medical Necessity

Q4: Is the Virginia utilization review statute (Chapter 54, Title 38.2) sufficient to ensure adequate mechanisms for resolving disputes in medical necessity determinations? and

Q5: How do HMOs obtain the services of the “peer” required in 38.2-5408.B?

QualChoice: We use the statute very little, as our basic decision making is left to the Primary Care Physician (PCP). So we have had to do very few medical reviews. When we have had determinations, our Medical Director is always involved. We obtain peers from our provider community, and we also use outside resources to help us make a determination.

Q6: How do you educate your members and providers about the review option?

QualChoice: It is in their contract.

Question from Study Group member: Are specialized services carved out by the PCP and mental health multiple options?

MAMSI: Purchasers usually carve out services to provide what they might feel they can do best. Purchasers ultimately decide.

Study Group Representative of the Virginia Association of HMOs: In the last Roundtable providers indicated that they felt that decisions were made by HMOs that were not in the patient’s best interest, and that were left “flat-footed,” without recourse. It was amazing that the providers at the Roundtable had not ever used the statute, and were not familiar with the statute. So what we’re wondering is, if there’s a UR question of medical necessity for, say, durable medical equipment or for a formulary drug, and if the normal processes that you use for some reason don’t work, is that the kind of decision that could go through the appeal process?

Aetna/US Healthcare: That’s a complicated question. Some of this is clear cut, other aspects less so. The question is whether the services meet general standards of care, not necessarily the physician’s standards of care. First, the case would go to a reconsideration group, then it would go to a member of the medical community which would include the Medical Director, and if the dispute was not resolved at that level, it would then go to mediation. So there are multiple levels of dispute resolution that members can use.

NYL Care Health: The statute is almost never used. The appeal process provided by the UR is not used, partially because physicians are not familiar with it, but usually because the problem is resolved at a lower level about what is actually covered by the contract and what is medically necessary. What is appropriate coverage is not so black and white that people can take a hard stand. For the most part, people are profoundly interested in the well-being of the patient, so accommodation often occurs.

Study Group Representative of the Bureau of Insurance: At the last Roundtable, one provider had tried to use the review process. Could you give some numbers on what you mean when you say the statute is “almost never used?” Where is it being used?

NYL Care Health Plans: We used it only a handful of times in the last two years.

Prudential: We've used it only one or two times since the statute was enacted. What we've done since the statute was enacted is review the whole compliant process. At the reconsideration level, if we decide we goofed and it doesn't make sense, we give it to them. We once had about 100 reconsiderations per quarter, and now we've gotten it down to about 32 or 33 per quarter. Of these, only one got to what we would consider an appeals level.

Question from Study Group member: Has the statute provided an incentive for HMO's to resolve disputes before they get to an appeals level?

MAMSI - We wanted to make sure that when something was denied, it conformed with the law. So rather than looking at just that piece, we would look at the whole appeals mechanism. All of it is part of the appeals process, from reconsideration onward.

Capital Care: There has been a lot of change in the appeals and review process in the last two years. HMOs have done a lot to improve their own internal mechanisms since the statute was enacted.

***Study Group Representative of the Medical Society of Virginia:* How are you selecting companies that you are subcontracting to, such as pharmacies, and what do you do to ensure patient confidentiality? One case brought to our attention at the last Roundtable involved a situation where a patient got a letter from a drug company with personal information about the patient in the letter, in which the drug company told the patient that the drug doesn't exist, when in fact it does exist. What quality values do you place on the entities with which you subcontract?**

Capital Care: We do a review of these entities, very similar to the NCQA (National Committee on Quality Assurance) review and standards that we hold ourselves accountable to. So we look at their quality improvement plan, accessibility of their network, how they have credentialed networks, and we pull records and patient charts. They are required to periodically and frequently report on the things they have approved and denied. There is an onsite survey with the entity before we contract with them. Thus, we hold subsystems accountable for the same things that HMO's are responsible for.

MAMSI: There is a great deal of difference between plans. Purchasers are carving out certain components that make it difficult for an individual provider or consumer to catch.

Kaiser Foundation: If the individual plan is NCQA-approved, and if they have delegated or carved out particular services, they are required to meet the same standards in overseeing that carve-out to ensure they still meet NCQA standards. So the question is how do they approach quality oversight? If the purchaser doesn't do this, then the plan has the responsibility to deal with this.

Health Keepers, Trigon: There are services that an employer may carve out, that the plan doesn't provide at all. This is in contrast with services that the plan might subcontract and delegate. We need to be careful that we are clear about the services that the employer has chosen to carve out and go directly to a member. We can provide the patient some assistance and direct them back to their employer. But in those

circumstances, there may not be much else we can do. Pharmacies would be an example of this.

Questions from Study Group Representative of the Department of Health Professions: We received an unsolicited letter in the last week regarding an issue in dentistry. The issue concerned a report submitted by a provider recommending the removal of the patient's impacted molars, which was subsequently denied by the plan in a letter which said that this was not symptomatic and did not require removal. This is a situation in which someone who hasn't seen the patient and cannot examine the patient is substituting their judgment about what is or is not essential. This is the kind of situation that everyone here wants to avoid. What can we give to people to assure them that this is abnormal, and that it will not be the norm?

Capital Care: I would wonder if the dentist had contacted the medical professional who made this decision. That is where we want the dialogue to start. The provider may think there is some big bureaucratic process to follow, but they should just call the HMO and do whatever is needed to contact the person who made that medical decision.

NYL Care Health Plans: While all of us would like HMOs to stay out of the practice of medicine, not all decisions made by treating physicians should be deferred to. We had an incident of a woman in Maryland who needed both medical and psychiatric treatment. The medical condition was treated first in a hospital. The physician then wished to keep the patient in the hospital, while we pointed out that hospital did not have psychiatric facilities. In that kind of dispute we cannot always do what the physician wants. On the other hand, we certainly don't want to be in a position of making medical decisions for the physician. It is important to be clear about the distinction between medical decisions that concern the treatment of the patient and decisions that might depart the boundaries of the contract. These are very different types of decisions.

Health Keepers, Trigon: The other mechanism that HMOs have in place is to make sure that any information concerning coverage is distributed after we receive information. If errors are made then we notify physicians and members stating their right to appeal. We want the physician to come back to us and tell us if we've made a mistake, rather than sending a letter to the state.

The group concurred that it is a common practice among all HMOs to send a letter stating the right to appeal.

Sentara: In the situation described, perhaps there was a lack of documentation or lack of clarity on the part of the dentist. I do not believe non-medical professionals would make or attempt to make the kind of decision described. The appeals process is sent out with every single denial, so I would hope that the dentist would call right back or use the appeals process in place.

MAMSI: This is a problem because providers don't always have the ability to fully document cases in a way that HMOs require. If there is a pattern of this, then perhaps the HMO could help the provider find ways to document the case more appropriately.

Q8: Who should be responsible for medical necessity determinations?

Capital Care: It is important to go back to the difference between determination of medically appropriate medical care and determination of medical necessity in terms of the benefits provided by the plan. The HMO

defines what is medically necessary, not what is appropriate.

MAMSI: An example of this would be an employer who chose to not purchase the option of transplants. So this benefit was denied the patient, even though there was no dispute that the transplant was medically appropriate.

Question from Study Group member: Did I hear you say that, by definition, medical necessity is whatever you stipulate in the contract the coverage is?

Capital Care: The contract has different types of benefits. A patient may need to have surgery, for example. Medical necessity would be determining whether the surgery needs to be performed on an outpatient or inpatient basis, or whether the person needs to remain hospitalized or be placed in a nursing home. The care is needed, so the question is what *level* of care is appropriate. That is how we use medical necessity determinations.

Question from Facilitator: So the determination of medical necessity should reside with the plan?

Capital Care: Yes, we define medical necessity. No benefits are provided for treatment that is not medically necessary.

Question from Facilitator: So, to push the question further, do you all agree that the determination of what is medically necessary should reside with the plan?

NYL Care Health Plans: Yes, so long as we keep the distinction between the medical decision of the treating physician and the benefit decision of the HMO, which is backed up by an appeals process that assures that the HMO decision is not arbitrary and is rooted in the medical community in which the plan operates. The ultimate recourse in all of these decisions is the standards of care of the community, as voiced by the physicians and other providers, who will ultimately decide whether utilization based on medical necessity is appropriate. We are *not* saying that HMOs should make decisions about what is appropriate medical care, and we are *not* saying that the HMOs decision about benefits is entirely in the hands of the HMO without recourse elsewhere.

Sentara: We have a contractual obligation to our employer groups to perform that function, to determine the extent of care provided under the contract that was negotiated by them.

[Everyone concurred with the facilitator's summary that there are three tiers: the tier of the physician who determines what is medically appropriate, the tier of the plan that determines the level of care that is deemed necessary contractually, and the last tier would be the appeals process that could be used in the event of a dispute.]

Quality Providers

Q9: How does the HMO address new technology and procedures? When is a procedure/ technology/ therapy deemed accepted practice and no longer experimental? What input are contracted providers permitted in this process?

Prudential: On a national basis, new procedures are reviewed in an ongoing manner. This includes getting information so that our practitioners are aware of new procedures, usually by way of a literature review that looks for peer review, double-blind clinical trials, and FDA-approval. If a procedure is determined conditionally eligible, and the last review was in 1996, I would first get information from the provider, look at the information about the individual patient, and see if the provider knows of more current literature. If we make a decision on an individual case based on new information, then I need to pass that on to the national level so it gets distributed throughout the country.

Aetna/US Healthcare: We need to abide by our oath of “First do no harm.” There are as many alternative treatments as there are allopathic procedures. To make sure that we do no harm, medical decisions must be done within a peer-reviewed perspective. Therefore, there must be peer review of our decisions and actions. For example, the new mammogram policies are based on data and studies that show the new technology or service is indeed effective and either enhances survival or the quality of life. That is our responsibility to our members. Secondly, we update the guidelines when there is a preponderance of evidence as supplied by oversight agencies, such as in the case of the American Cancer Society updating the guidelines for mammography.

Question from the Facilitator: Who in your agency decides that there is a preponderance of evidence?

Aetna/ US Healthcare: We have a core group that is responsible for responding to the issues, to new initiatives and technologies and policies to make sure that we are staying current. It is an ongoing process in which we are constantly reviewing procedures. On the other hand we are also trying to make sure that patients are not subject to any harm.

Q10: What are some of the economic and other incentives currently used by HMOs that may affect quality of care, either positively or negatively?

NYL Health Care Plans: Speaking in broad terms, we have a variety of mechanisms for rewarding quality care in the bulk of our contracts. For example, patient satisfaction is one measure of quality. For many of our providers this is integrated into the bonus structure or capitation build-up structure. We also reward access to care by having open panels, to increase the bonus potential, rather than having closed panels. We try to integrate this type of information into the care. If we detect a gross deviation from the norm, that would be factored into a bonus system.

Aetna/US Healthcare: Our system explicitly includes multiple monitoring, where physicians are monitored and rewarded for performance based on a number of different quality measures. We compensate accordingly, as well. We can increase their capitation based on performance according to the quality measures. All of this information is published in national journals.

Q12: How does the HMO address PCPs who appear to be high utilizers of referrals, expensive procedures, hospital-based care? What about physicians who appear to be underutilizers?

Kaiser Foundation: We have a group practice model. We identify physicians who deviate significantly by looking at their utilization, such as prescribing, or hospital utilization. The first question is whether the population that they’re serving has some variation from the remainder of the group, or are they operating in

an area that may be serving a different demographic group of patients within our entire service area. That usually explains the variations in the practice. If it does not, then the opportunity usually is taken to meet with the physician to educate them about how their patterns of practice in terms of utilization compare with their peers.

Prudential: We use the same process. These kinds of approaches are effective because clinical decision is grounded in three things: in science, in judgment, and habits and biases. The last area, of habits and biases, is the one that we try to address. So you can see that this might translate into a physician always prescribing a particular antibiotic, or a surgeon always wanting to keep patients in the hospital until they're eating steak as opposed to their peers who discharge the patients when they're still on full liquids. So we educate them about how their peers are operating, and see if there are adjustments they can make without affecting the care provided to the patient.

Question from the Facilitator: Does anyone *not* follow this pattern, of first investigating the possible reasons for the deviation in practice and then talking with the physician personally?

HealthKeepers, Trigon: We follow the process, but since we are not working in a group model we don't have readily available clinical information. So we have a pattern of giving the information to the physicians up-front, showing them their peer comparison, and then having a discussion with the physicians on the high end, the low end, and those with questions. So, in the absence of clinical information like in the other model, we often have to first disseminate information with profiles and then have a discussion.

NYL Care Health Plans: When doctors are given information on how they compare, it is really useful.

HealthKeepers, Trigon: The process described applies generally to PCPs, but it is a little different for specialists, since we may not have sufficient data to generate peer comparisons and trends. Our PCP are profiled the most, about three times per year. Specialists are not profiled very frequently.

Question from the Facilitator: In a situation like this, when you've talked with the physician about how they compare with their peers, have you ever had to terminate "for cause" if they don't adjust?

MAMSI: Yes, but very rarely. We have terminated someone only once in five years, when a doctor was released for failure to adjust. This is not done lightly, and the physician is usually given two to three years to adjust. And there is lots of communication that occurs prior to termination.

Question from Study Group member: As the final step, do you let the physician know why he was terminated?

MAMSI: Yes, the letter spells it out clearly.

NYL Care Health Plans: We have never terminated a physician based on profiles. The only termination based on overutilization is a Maryland physician who was terminated because he was using procedures that were not at all indicated by the diagnostic steps that led up to those procedures. We also had the Board of Professional Quality (BPQA) at the assessment. Health plans do not terminate providers lightly, because it

can be exceptionally expensive.

Study Group Representative of Virginia Association of HMOs: For clarification purposes, this kind of termination is distinct from a plan that is developing a subnetwork of specialists by an RFP process. Some doctors might consider the RFP process a kind of termination, but that is not what we're talking about here. Dr. Daniels and Tanya Denckla thanked everyone for participating in the Roundtable and sharing their views. A summary of the Roundtable session is expected to be posted by the end of May at the website address: <http://www.vdh.state.va.us>.

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Focused Roundtable for Consumers

**May 23, 1997
9 a.m. - 12 noon**

Scott Daniels, Ph.D., Assistant Commissioner for Health Policy, welcomed all of the participants and explained that the Study Group on Managed Care in Virginia will be making a report on October 1, 1997. He explained that through this Focused Roundtable the Study Group wished to learn more about consumer and patient concerns and problems with managed care organizations. The group is not focusing on HMOs specifically, but all types of managed care organizations, so he invited everyone to speak to experiences with any type.

The purpose of this and the previous two Focused Roundtables has been to discuss the role of the Commonwealth in monitoring and improving the quality of care delivered in managed care organizations, including HMOs. Part of the research process is looking at the nature of complaints and grievances, and analyzing how that information might provide feedback into how the system could be improved. In the past two meetings, the Study Group has heard from HMOs and providers who told the group about how they handle complaints and grievances and how their quality improvement systems operate.

Dr. Daniels reminded the Roundtable members that the meeting would be informal. At this meeting, three broad categories were represented: (1) patients and advocacy groups, (2) complaint managers, and (3) the purchasing community. The complaint managers represented the Employee Health Benefit Program, the Center for Health Services and Consumer Protections, the Bureau of Insurance, and the Department of Health Professions. The purchasing community included large companies with protected risks and smaller employers. Dr. Daniels commended the patients for their courage and for taking time out of their schedules to share with the study group. He noted that the study group members and others may want to ask the patients questions for clarification, but that the discussions would strive to be non-invasive.

Dr. Daniels reminded the group that anything that Virginia may do in relation to HB 2785 will really only affect 25% of covered lives in Virginia. The majority of covered lives in Virginia are in plans regulated by federal laws. For instance, the majority of privately covered lives are in self-funded plans governed by the Employee Retirement Income Security Act (ERISA). He asked the group to remember that very little can be done for enrollees who are employed by large corporations with self-funded plans. ERISA pre-empts state laws regulating quality of care and consumer protection. Other health programs

such as Medicare, Medicaid and CHAMPUS are also controlled primarily by the federal government.

A Study Group member added to Dr. Daniels's opening statements. She agreed that Dr. Daniels was absolutely right about the consequences of federal control, but wanted to remind everyone of the potential this group holds in terms of educating consumers. This type of benefit would not require mandatory regulations and will be a great asset to Virginia. Dr. Daniels concurred.

Dr. Daniels then introduced the Roundtable facilitator, Frank Dukes, Ph.D., from the Institute for Environmental Negotiation at UVA. Dr. Dukes welcomed all of the participants, particularly the patients. He noted that the stories would be heard in confidence and that names would not be used in the meeting summaries. He asked that members of the Study Group and other attendees respect the fact that the patients would be sharing private and sometime intensely personal stories, which should be kept confidential. As ground rules for this informal discussion, Dr. Dukes suggested that speakers be concise and remember that we are here to learn from all participants. He noted that it was his job to make sure all of the interests were heard. Dr. Dukes also announced that one of the patients invited to speak had been in a car accident on the way to the meeting and would be arriving an hour later. He hoped that the accident was not serious. He then asked participants to identify themselves and their organizations.

Dr. Daniels introduced Dr. David Buchsbaum, Medical Director for Aetna US Health Care Virginia, who he asked to attend the meeting to answer any clinical questions related to HMO practices that may arise during the discussion. Dr. Dukes asked the observers to introduce themselves and reviewed the agenda.

Patients' Experiences

Patient #1

The speaker began by thanking the group for allowing him to represent his daughter at the meeting. His employer is enrolled in a large managed care organization. He stated that the people sitting around the table scare him because of what they may be able to do or not do for the system. The speaker passed around pictures of his daughter on the first day of her life and on her first birthday. He related how he and his wife had made the decision three days after she was born to have her disconnected from her ventilator, but she did not die.

His daughter was born with her cerebral cortex almost totally destroyed. There was no evidence of how it had happened, but doctors thought it had happened within 24-hours of her delivery. The doctors also said she would not live to one year, but she has.

The speaker stated that any doctor of neurology will testify that a child's most important developmental years are from birth to the age of three. The only reason his daughter is still alive today is because of the caring professionals at her hospital and the care he and his wife have given her 24 hours a day 7 days a week. He stated that his daughter's development will always come first to him and his wife no matter what the cost.

When his daughter was born, he and his wife had enough to worry about, without being concerned about how much the insurance would or would not cover. He had felt that since he worked for one of Virginia's top employers he and his family would be taken care of, but he was wrong. The managed care organization (MCO) refused to pay his daughter's bills for physical therapy. The speaker challenged

their decision and was told that his daughter's condition was considered "developmental delay." The MCO does not cover any "developmental treatments" to any child under the age of 18 outside of any contract requirements with the speaker's employer. He reminded listeners that a child's most important developmental years are from birth to age three. The MCO has refused the chance for his daughter to have a certain quality of life. He wondered what he had insurance for, if not to insure that the members of his family are given a chance at recovery and some quality of life when injury, sickness, or disease strikes. He wondered about a big business that could deny an infant the chance to be all that he or she can be, not to mention the affect that denial has on the other members of the patient's family. He and his wife have been through a tremendous amount to give his daughter what she needs and deserves as a human being.

His daughter is one year old. She is blind, she can't sit up, she can't crawl or stand, she can't kiss or hug and may never do these things without therapy. She will always require acute care. As her father, he realizes that she will never do the things we take for granted, but she can at least be given a chance to do all of the things she can possibly do. The only way to accomplish that is to require MCOs to provide assistance for a child's development from birth to the age of three, when state and federal programs are available for developmental treatments. He feels that he has been entrusted to care for his daughter by God and implores the group to use any power they might have to help him and all of the many children and families in similar situations.

Questions and comments related to Patient #1's experience from the study group included:

Patient Advocate Foundation: There is frequently a fine line of differentiation between intervention for patients such as Patient #1's daughter based on developmental and rehabilitative services. Patient #1's daughter has fallen through the crack between those two definitions. Virginia looked at this question during the 1997 General Assembly and made the decision that cases such as the one just related needed to be addressed. Delegate Mary T. Christian introduced legislation this year to change the wording so that children age birth to three can have the services necessary for conditions that are developmental. That law has passed and goes into effect on July 1, 1997. She wanted to bring this up because it is a problem and has been recognized as such in Virginia.

Q. Consolidated Coalition for Quality Health Care: *Is the employer's plan an ERISA Plan? And will a state regulation even apply to the case in question if it is an ERISA Plan?*

Patient Advocate Foundation: No, a state regulation will not apply to this particular case because it is an ERISA Plan, but it will set precedence on the state level for indemnity insurance. It often plays out that after legislation is passed, self-insured plans will begin to look at that issue and may follow suit.

Study Group Member: The statute that passed protects only state employees. The broader issue of coverage under private plans is being considered this year by the Mandated Benefits Commission.

Patient #2

Patient #2 opened her comments by saying that her experience is not nearly as severe as Patient #1's. In the Spring of 1994 during an annual physical, she mentioned to her primary care physician that she was experiencing dizzy spells about once or twice a month. The doctor asked her to keep a log. In June

of 1994 her most significant dizzy spell caused her to black out while she was driving. Fortunately, she did not hit anything or anyone. Her primary care physician ordered a brain scan, a carotid test, and a visit with a cardiologist. She underwent several tests and wore a heart monitor for 30 days. None of the tests showed any problem.

In the Spring of 1995, she experienced a rapid heart beat on occasion. Again, no cause for the problem could be determined. A physician friend of her husband suggested that she see an electrophysiologist. She went back to her primary care physician and mentioned the suggestion. He gave her a referral, and she went to visit the electrophysiologist in October of 1995. He recommended a catheter ablation, but because of the possible side effects (a stroke) and her situation at work, she put it off.

In November of 1996, she went back to the electrophysiologist and expressed concern that the dizzy spells and the rapid heart beat might be two different problems. He ordered a monitor that could relate the 90 seconds preceding any episode. The results indicated (in layperson's terms) that the electrical impulses to her heart were getting off-track and causing both problems.

On January 6, 1997, she and her doctor scheduled the catheter ablation procedure for January 21, 1997. One week prior to the scheduled procedure, her doctor called her at home at night to tell her that her insurance company had refused to cover the procedure because they hadn't tried medication. Her doctor was upset and asked her if she minded if he appealed the decision, which she said was fine. He spoke to the doctors at the insurance company, and they reversed their decision and agreed to cover the procedure, but too late for the scheduled appointment. She was on the medication the doctor had prescribed when the procedure was canceled, and psychologically, she wasn't ready to set another date.

After having another rapid heart beat episode while on the medication, she decided to go ahead with the procedure. The procedure took place on March 21, 1997, and she has had no rapid heart beat episodes or dizzy spells since.

This problem had gone on for over three years, and though she had only blacked out once, she was very worried about it happening again. Her greatest fear was that it might happen again while she was driving and that she might injure or kill herself or someone else.

Questions and comments related to Patient #2's experiences included:

Q. Consolidated Coalition for Quality Health Care: *How long did the appeals process take?*

Patient #2: The appeals process took about a week. Because it took so long the original procedure had to be canceled.

Patient #3

Patient #3 began by saying that since her experience took place over a number of months, she was going to leave out some of the details. On November 6, she called her HMO and complained of extreme back pain, intolerable chest pain, and shortness of breath. She called the emergency number at about 7:30 am and was barely able to speak. The operator on the phone was obviously concerned. She spoke to the supervisor, who told her to call the center near her home and make an appointment. She made an

appointment for 11:00 that morning.

The doctor she saw did not take any chest x-rays, checked her heart with a stethoscope, prescribed Percoset, and sent her home. She felt much better, but she still had pain and could not sleep laying down at night.

On December 12, her right leg began to swell. Since she wasn't happy with her physician at the HMO, she went to a physician she knew who specialized in reconstructing leg injuries. The specialist was not part of the HMO plan. The specialist was certain that she had a blood clot. He immediately sent her to a hospital less than a block from his office. The physician called the HMO to ask for coverage for the surgery, and the HMO said no. They said she should go home and make an appointment with the primary care physician in the morning. The specialist refused to send her home, feeling that her life was in jeopardy. He called the primary care physician and argued with her, but she refused to approve the surgery.

The HMO decided to cover the operation but made her move to a different hospital significantly farther from her home. The specialist brought her to the radiology department, where they took a Doppler of her leg and did in fact find a blood clot. She was admitted to the hospital without the approval of her primary care physician, but the HMO did cover the procedure. Her primary care physician did not visit her while she was in the hospital. She was attended to by a general practitioner. He was very nice and tried to explain her situation to her, though he did not know much about her condition.

On December 17, she was released from the hospital with little instruction as to how to proceed and no warning about the possible side effects the medication she was given (birth defects). It turned out that the birth control pills she was taking probably caused the blood clot, and she hadn't known about that risk either. Twelve hours after returning home, she started having pains in her right leg again. She called the general practitioner, who did not have any explanation, so she called the specialist. The specialist recommended that she see a hematologist.

The HMO would not cover a trip to the hematologist, but she decided it was important and went anyway. The hematologist did blood work and asked her to go home until he got the results. In the evening, he called with the results, and something was wrong. The hematologist told her to go to the hospital immediately because the blood clot was probably propagating. She called the general practitioner, who was baffled by the situation but approved her admission to the hospital. She called her original primary care physician, who once again told her she would not approve her admission to the hospital. Patient #3 told the primary care physician that she was going to the hospital anyway.

At the hospital, the hematologist spent two hours trying to find someone at the HMO who would approve Patient #3's admission to the hospital. They finally approved her admission, and the technicians performed another Doppler. The blood clot had propagated, and they detected two more.

Patient #3 feels that not being admitted to a hospital, or any hospital, was absurd. She realizes now that she probably should have just gone to the emergency room because it would have been harder for the HMO to refuse coverage. On two separate occasions, Patient #3 was told her care would not be covered in hospitals that were, in fact, listed in the organization's book.

While in the hospital, she made a formal oral complaint about her primary care physician, saying that she thought the physician had made some poor decisions. The HMO was supposed to follow up on the

complaints, but no one ever contacted Patient #3. She decided to make a formal written complaint. She went through the official procedure and attended a meeting at which she explained the experience. The people at the meeting agreed that her admittance to the hospital should not have been delayed and that she had been treated poorly, but the formal written response stated that nothing had been done wrong and that they would not take any action.

She decided to contact the Insurance Commissioner's Office. After speaking to state representatives in several different departments she found that the Commonwealth really doesn't have any power to regulate or reprimand HMOs when they make poor decisions or regulate or reprimand physicians who are part of HMOs when they make poor decisions.

Patient #3 feels lucky to be alive today and believes that she is here only because the specialist looked after her. She feels that the HMO must have offered some kind of financial incentive to the primary care physician that lead her to refuse the patient's admittance to the hospital. She couldn't believe that the doctor would refuse her admittance even with test results indicating that she had a blood clot.

Questions and comments related to Patient #3's experience included:

Q. Rash & Associates: *If the original primary care physician was an employee of the HMO, what was the HMO's policy on switching primary care physicians? Why couldn't you switch?*

Patient #3: The physician was an employee of the HMO and was not private practice. The HMO allows patients to switch their primary care physician at the first of the month. I had selected a different primary care physician, but I never saw the new one.

Q. Rash & Associates: *What reason did the HMO give for why you could not be admitted to two hospitals that were listed in the HMO's publication?*

Patient #3: The HMO never responded to that question in either my verbal question or written complaint.

Q. Study Group Member: *Should the complaint about the physician have been made to the Virginia Department of Health Professions? And how would it have been handled?*

Virginia Department of Health Professions #1: Yes, the complaint about the physician could have been made to VDHP. The complaint intake analyst would have reviewed it. Then they would go to the complainant and make a decision whether the case should be investigated. The case would be referred to the Board of Medicine, where they would decide whether the physician was practicing below the standard of care. This procedure would deal with the general behavior of the primary care physician, but not necessarily the care the specific patient was receiving.

Q. Virginia Health Quality Center: *Were you (Patient #3) advised to talk to the Board of Medicine concerning this specific physician?*

Patient #3: No, my contact with the state was a little confusing. I didn't really know where to go.

Virginia Department of Health Professions #1: We would have referred that matter to the Bureau of Insurance.

Virginia Department of Health Professions #2: There are so many things involved in this type of issue, one of which is the decision-making of the primary care physician and the contact between the physician and the patient. Another issue is the question of the coverage and how it effects the relationship between them. This case is one we definitely would have looked at through our complaint process, though the outcome in this case can not be predicted. Our office can deal with the doctor, but not with the HMO.

Q. Consolidated Coalition for Quality Care: *Does the State of Virginia have laws for a prudent lay person definition of emergency services?*

General group: Yes.

Q. Consolidated Coalition for Quality Care: *Does Virginia have laws stipulating that individual members of an HMO should have their choice of a primary care physician and can switch?*

Study Group Member: I believe there is statutory language, but I will have to check.

Q. Consolidated Coalition for Quality Care: *Does Virginia have statutory language that states that individual enrollees can see at least a summary of the contract between the physician and the HMO to understand what the incentives are for their primary care physician?*

Study Group Member: No. By statute, the information is available to the purchaser of the plan, meaning the employer of the enrollee.

Consolidated Coalition for Quality Care: This is a very enlightening case that brings out a lot of issues. It can inform how the state might respond. All of the stories are very enlightening.

Q. Virginia Health Quality Center #2: *How did the Bureau of Insurance handle your (Patient #3) concern?*

Patient #3: I believe the case has been closed. I contacted them on a number of occasions. The last communication implied that there was nothing more they could do, but I might be wrong.

Q. Consolidated Coalition for Quality Care: *How did the plan respond to your (Patient #3) formal complaints?*

Patient #3: The HMO did not respond in any meaningful way. I received responses, but they never responded to the complaint about the primary care physician directly. They said they had investigated, that they were interested and concerned, but they had not found anything wrong. They did allow me to chose a new primary care physician.

VDH, Center for Health Care Services and Consumer Protection #1: Patient #3's complaints were referred to our office to investigation of health care quality issues. We also corresponded with the HMO and got no specific response. The last communication we received from the HMO stated that they had taken "appropriate action", but when we asked them what "appropriate action" meant, they repeated the statement with no explanation. This case is still open; we are still pursuing it.

Q. Virginia Department of Health, Staff: *There are required reports that health plans or hospitals make about their health care providers. Would this have applied here?*

Virginia Department of Health Professions #1: Any licensed health care provider can have our complaint toll-free number. It is on the license of every practitioner, in the blue pages of the phone book, etc. There is required reporting of some health care instances in the state, basically when a loss of privileges has resulted. If the Commissioner of Health or other official has knowledge that some one is practicing in violation of the laws covering the practice, that must be reported to us.

Patient #4

Patient #4 explained that her story is rather lengthy and passed around a written summary of events. In 1995, Patient #4 was in two different car accidents. In May of 1995, she was hit from behind when she slowed to avoid another car. She was insured through her employer with HMO A. She had to fight with HMO A to get her bills paid throughout her treatment. The HMO did not acknowledge her bills until an attorney got on the phone and discussed it heatedly with them. Because of this experience, Patient #4's employer decided to switch to another plan. The change was scheduled for December of 1995.

In November of 1995, only seven days before treatment for the first accident was to be completed, she was involved in another accident. She was again hit from behind. She knew she was going to be hit, and she braced herself with her hands on the steering wheel to keep from injuring her neck and shoulders. Bracing herself injured her hands and elbow.

The second accident occurred only nine days before her employer was going to switch from HMO A to HMO B. The people in her company were now worried because she would need treatment, and her injuries would be considered a pre-existing condition. The sales representative from HMO B said there would be no problem. They also asked if the doctors who were currently treating her would be covered. They asked these questions numerous times and were always told that there would be no problem.

Since then, she has had nothing but trouble with HMO B. Her doctor, who started the treatment in December told her that he would have to perform surgery to fix her injury, and they scheduled the procedure for February. It turned out that the orthopedic center at which she was being cared for was going to drop from HMO B's list of care providers. The center assured her that they had made arrangements for her surgery to be covered, and she continued treatment.

The surgery was performed, but one of her hands did not respond as well to treatment as they had wished. Her doctor felt that further surgery for carpal tunnel syndrome was needed. Patient #4

approached HMO B asking whether she could continue with this doctor since she had already been through so much. Representatives at HMO B said she would have to appeal because the doctor was no longer part of the plan. They said the appeal process would take about two weeks.

The appeal process stretched to take over two months and ended in HMO B's denial of coverage. They finally gave approval after Patient #4 faxed all of her notes showing that she had done exactly what she was supposed to do (she had worked for an attorney and had learned to take good notes). She had followed every requirement properly. They called her at night saying that they had news for her and that they would call her in the morning. They did, and they approved her doctor for the surgery.

Finally, the doctor was able to take x-rays of her hand only to find out that in addition to the carpal tunnel, there was a problem with her joint. She and her doctor anticipated that there would be a problem with HMO B, but they asked for coverage anyway. To her knowledge, HMO B has never responded to that request.

She was tired of waiting and went to another doctor who was part of the plan. Patient #4 stated that if she had known that it would take 2 or 3 months to receive an answer to the appeal, she wouldn't have waited. Her injury was getting worse during the time that she was waiting and needed to be addressed. Over the past year she has had four surgeries; each time there has been a problem with HMO B and getting procedures approved.

Patient #4 is most annoyed by the fact that she tried to follow the procedures and tried to do everything they asked her to do. They told her it would be easy to go through the process, but it wasn't. She has been screamed at by a representative from the HMO, who told her that she was creating the problem and that she should never have chosen a doctor who was outside of the plan. However, when she chose her doctor he was part of the plan and had no reason to believe that he would leave the plan. That decision wasn't made until her treatment was well underway.

HMOs do not treat you the way they say they are going to, and Patient #4 questions some of the rules HMOs require enrollees to follow. The last time she was in the hospital, she struggled with the HMO. She needed a wheel chair, and her doctor called to get one through the HMO. She was supposed to leave around 10 a.m., but they came and told her that they could not get a wheel chair for her until 4 or 5 p.m. She asked why. They just repeated that they couldn't get one. Then she and representatives from the hospital started calling the HMO to get it straightened out. At one point a representative from the HMO told her that someone was speaking to the caseworker, but the case worker was in her room and wasn't speaking to anyone at the HMO.

They finally found out that the wheel chair the HMO had ordered for her was being transported from a city in a completely different part of Virginia. She asked the HMO if they were going to pay for the additional time she would be in the hospital because the hospital would not release her without a wheel chair. They said that she would have to pay for it. She told them she would not pay for the extra time, that they would have to, and they finally got a wheel chair to her within about an hour and a half. The wheel chair came from a company that was much nearer to her hospital. She wonders why they did not do that in the first place.

Patient #4 also questions the process for approvals for payments for treatments. She needed a special kind of brace for her arm. If the brace can be purchased in a health supply store, the insurance does not

cover the cost. If the brace is custom made, then the cost may be covered. When they were getting ready to put the brace on her hand, the insurance specialist from her orthopedic center called the HMO and was told that the cost would not be covered. The same day, the specialist called back again and was told that the cost would be covered. Patient #4 feels that the two representatives, sitting side by side, were looking in different manuals. The same question was asked to two different people; one looked in one manual the other looked in a different manual, and they arrived at different answers. Patient #4 questions the credibility of the HMO. The brace was \$60. She paid a \$15 co-pay. The HMO paid \$5. Her doctor paid the rest. She wonders how long her doctor can afford to continue as part of the HMO. The \$20 he received did not even cover the cost of materials.

Questions and comments related to Patient #4's experience included:

Q. Study Group Member: *What role did your employer play during this time?*

Patient #4: My employer mostly wanted me to be at work as an effective employee. Through the surgery they were supportive. They let me use the fax machine to communicate with the HMO, and they gave me time to come to this Roundtable. My employer tried to change insurance companies again this year when they were informed that the enrollees would have to pay twice as much for coverage.

Q. Rash & Associates: *How many employees are in your company?*

Patient #4: There are nine at my location, and there are several other locations with a similar number of employees.

Q. Consolidated Coalition for Quality Health Care: *Are there any statutory provisions in Virginia, as there are in other states, for the continuation of provider relationships when employers change HMO plans?*

Study Group Member: In Virginia, the statute allows continuation of provider relationships for 60 days after the notice of termination, not until the end of the episode of care.

Consolidated Coalition for Quality Health Care: Maybe the law should say it should extend through the episode of care, instead of an arbitrary date.

Study Group Member: That was proposed at one time, but we ended up with 60 days.

Study Group Member: Most HMOs have guidelines for continuing care on a case by case basis.

Q. Rash & Associates: *Isn't continuation of provider-patient relationships treated differently by different HMOs?*

General Group: Yes.

Q. Patient #1: *As a consumer I have a real concern because my daughter has cerebral palsy that was diagnosed at birth. If my employer decides to change plans, do I only have 60 days to find a doctor who will take on my daughter as a patient for a pre-existing condition that is usually excluded from these programs anyway?*

Rash & Associates: The major problem would be that if they switched to a different HMO, there might not be a provider within the network that could render the appropriate care for your daughter. Pre-existing conditions are not the issue here. It is a question of finding someone who could continue the care and someone with whom you are comfortable continuing care.

Q. AARP: *Are the guidelines for continued care uniform or are they determined by the HMO?*

Study Group Member: The statute speaks to the time of notice. Beyond that point each HMO can deal with the process differently on a case by case basis.

Q. VDH, Center for Quality Health Care Services and Consumer Protection #2: *Does this include obstetrical care also, such as someone who was six months pregnant?*

Study Group Member: I do not know whether the statute speaks to that, but I know of no plan that has ever forced a pregnant patient to change obstetricians under the circumstances of the employer changing plans or the provider leaving the plan. If the provider leaves the state, that is a different question.

Rash & Associates: That is usually accommodated.

Patient #5

Patient #5 opened by mentioning that she feels just fine despite her car accident earlier that morning. She stated that today she would represent the Virginia Mental Health Consumers Association which protects the rights, dignity, and quality of care related to mental illness. In her professional life, she is a health care professional, but she is also a consumer of both mental health and other care services. Through her work and personal life, she is able to see many issues in the mental health care field.

Her first concern is what the previous conversation revolved around: access to appropriate choices. Persons with chronic illnesses, whether it is mental, something like diabetes, or anything that requires a specialist, are faced with some difficult decisions when they are choosing an insurance plan. The enrollee must choose between a primary care physician who coordinates all of their other care and the person who has been following them for a long time for episodic or chronic conditions. Often those doctors will be in the plan, but in many cases they are not. Many people are faced with the question of whether they can go outside of their plan's network. Often the answer from plans is that they can not go to a doctor who is outside of their plan network, so they take their chronic history to someone who has never treated them before.

Another question related to the choice of a plan is the availability of certain medications. When consumers ask these types of questions, they are often answered by the marketing people or sometimes the customer service representatives. Usually, the representatives try to answer the question well, but

often they can only tell the enrollee that a certain medication is available now but can't be guaranteed later. It is very important for people with chronic conditions to have more consistent information for their decision making. For those people who are healthy and rarely need to see a doctor, decision-making depends on cost and convenience. This is not the case for those with chronic conditions, and for them, the amount of information available to an applicant is a concern.

People are asking what the complaint process is, and they are not being given an understandable answer. They ask for it in writing, and it is not forthcoming. This is a problem.

For psychiatric care, and for other conditions as well, new medications are coming out all the time. These medications offer hope for recovery, but also offer a chance for HMO's to reduce their costs because these medications reduce the need for other kinds of services. Sometimes the new medications are not made part of the HMO in a timely way. This is confusing to the consumers, who may not be aware that the medication is out on the market. The doctors in the plans do know. Patient #5's organization has found that doctors in plans often are not permitted to tell consumers about new medications that are out on the market. When her organization is made aware of the new medications, they try to let consumers know and try to help them get access to the new medications.

Another issue is waiting time. Her organization has heard a number of complaints that the patient can get an appointment within a day or two, but must wait in the doctors office for a long time and take time off from work. They often have to wait for two or three hours. Often their physician was not enrolled in the HMO plan and joined later. Before the doctor joined the HMO, the waiting time was significantly shorter. The person who knows that they will have to take two or three hours off from work and does not have the type of job that affords them that luxury is frustrated by sitting in a doctors office and losing wages. Often, they do not return for care and that ultimately worsens conditions.

Providers have played a critical role in reducing the number of complaints. One of the things we have heard consistently from members of the General Assembly, HMO Management, and from other advocacy organizations is that there is just not a consistent record of complaints showing a problem. One of the things we have done very poorly is tracking complaints. Often a patient may go in to see a primary care physician or a specialist and have some barrier to getting service, but often the provider has taken on the burden of making sure the patient gets the care s/he needs. The doctor may not tell the patient that s/he is going to put in a special request to an HMO for a medication that is not readily available to the general, enrolled constituency. The patient may never know that someone has requested on his/her behalf and been denied.

Complaints are often ambiguous. People will call customer service with questions about the care they are or are not receiving, but they never put it in a formal complaint form. As customers, we contribute to the fact that complaints are not collected for all of the different issues.

There is a disconnect in the appeals process. The biggest problem is that consumers do not know how to navigate the system to appeal. It is very confusing and requires a high level of skill.

Out-of-network providers are another issue. Patient #5 recalled one case in which a potential enrollee asked the HMO whether an individual who was the HMO's medical director, but not listed as an approved provider, could be considered a provider under that plan. The consumer was seeing that doctor, who worked for the plan choosing "Best Practices" and performing other tasks, but was not allowed to continue seeing him. Patient #5 is not sure how this barrier can be relieved to allow patients to stay with

their doctors while abiding by the network's rules and regulations.

In mental health, HMOs normally offer 20 out-patient visits. Patients often complain that they can easily get one or two appointments, but that it is very difficult to actually have all 20 visits. Patients with serious disorders, such as schizophrenia, bi-polar disorder, depression, find it very difficult to complain. Unless they have a family member or someone within the provider network who will look out for them, they really do not have an advocate. There really is a need for an ombudsman service or someone else accessible to everyone.

This is a general list of some of the concerns. The last one is utilization review. Patient #5 described utilization review as an IRS audit. HMO representatives review the documented medical history of a patient, and by what is documented, they determine what type of care the patient is going to receive. Often utilization review is so external from a patient that simply brief contact with the patient and provider by the reviewer could improve the process, avoid denial of care, and ultimately, avoid the appeals process. Often, significant information is missing from the documentation. Patient #5 recalled an example that involved a psychiatric care patient who had been able to avoid in-patient care. The utilization review resulted in the denial of out-patient care, despite a 10 year history of responding well to out-patient care. The doctor said that in-patient care was unnecessary and that the patient had been maintained in an out-patient setting with intensive treatment. Unfortunately, the records did not document that clearly to the HMO, and the HMO ended up paying for a week of in-patient care that was wholly unnecessary. That is an extreme example, because often we hear stories that HMOs are not offering enough care, but it highlights the need for greater communication during utilization review. The interaction between the utilization review person, the doctor, and the patient needs to be more connected. The review is not an external function, and it should be done by a professional.

Best Practice guidelines are created by an HMO by looking at a specific condition and determining what the best course of treatment is for people who are in a diagnostically related group. It may be psychiatric or something like diabetes. The plan decides what the Best Practices are. Often other practices are not common knowledge to the patients. There are many treatments that come out that are not experimental that do not fall within the HMO's Best Practices. The patient may be with one HMO that uses one type of medication but change to another one with different set of Best Practices, possibly because one is less expensive. The second HMO might not allow the patient to continue using the same type of medication or treatment. Patient #5 wonders if there can be universal Best Practice Guidelines. This is a big challenge; we can't even get a national speed limit!

To summarize, the issues are:

- enrollment access to information about the services available
- complaint process and how to network with the providers
- access to new medications
- waiting time
- switching primary care physician (especially with psychiatrists)
- utilization review

Best Practices Guidelines

Discussion of Questions for Consumers

Facilitator Dr. Dukes opened the second part of the Focused Roundtable for Consumers by repeating the ground rules and inviting everyone to speak to the questions printed on the agenda. The questions were the following:

Please identify the most typical quality of care concerns that enrollees have about the quality of care provided by HMOs. Here are some categories of examples:

Access to care

Denial of care

The quality of providers

Pharmaceutical formulary

Timeliness of preauthorizations

Criteria for experimental care

Limitations of hospital length of stays, access to outpatient services

Are HMO enrollees provided with the kind of information that allows them to successfully understand and access HMO's complaint/grievance/appeals systems?

What have purchasers and consumer advocacy groups done to inform patients and consumers of existing appeal and complaint mechanisms?

How frequently do HMO enrollees access state regulatory complaint systems, and is the information they receive helpful? How could it be improved?

Is the state oversight authority sufficient to ensure that the complaints of individuals affected by the delivery of services within the HMOs will be adequately addressed? What needs to be done to ensure that it is adequate?

The facilitator opened the discussion by asking that all three categories of invited participants (patients and advocates, plan purchasers, and complaint managers) address the first question. He asked that people discuss the issues brought up by the first question, whether the examples cited made sense, if there are others that should be added, and any experiences that may illustrate their comments.

Quality of Care Concerns

Patient Advocate Foundation #1: While we handle patient calls from all 50 states, I have tried to tailor my remarks to Virginia. Quality of care becomes an issue when a patient is being redirected. If the redirection takes place before the patient is admitted to the hospital, then perhaps the redirection is beneficial to both the consumer and the HMO, given the need to manage medical costs in this country. However, the two instances we bring to the Committee today are of patients who were hospitalized in Northern Virginia and insured by an HMO in Northern Virginia. While hospitalized, they were informed

that they were going to have to be moved to another institution. In both cases, the physicians treating the patients protested the move of these patients from one hospital to another. In one instance the patient was going to be redirected to a hospital that was several hours away. This particular patient was in a very critical condition at that time. The patients were moved. The 35-year old gentleman who was the sickest of the two patients, died within four hours of his arrival at the second hospital. That is a quality of care issue that concerns us. If a patient needs to be redirected for care, our recommendation is that the redirection come before the point of hospitalization and that the patient and the treating physician have an opportunity to discuss it. The specifics of that case have been provided to the Study Group.

Study Group Member: I would like to make one comment about that, and I may stand to be corrected. In the State of Virginia, an HMO, unless it is the direct provider of care, is not subject to any type of medical malpractice. A consumer has very little chance of pursuing that through the legal system, unless you were to sue on the basis of a violation of the contract, which is a much more limited right. You cannot go to the legal system to complain about the HMO's decision in requiring a move that resulted in somebody's death.

Study Group Member: (to Patient Advocate Foundation #1) I assume that you are not suggesting that transfer to another facility is, in and of itself, an inappropriate judgment, for medical reasons.

Patient Advocate Foundation #1: We are saying that if there is a decision to move a patient that it should be done with the full support of the treating physician and, hopefully, with the full support of the patient. In these cases, the treating physician urged the HMO not to move these patients.

Rash & Associates: What reason was given for the patients' redirection?

Patient Advocate Foundation #1: It was a financial reason. The HMO notified the hospitals where the patients were staying that they would no longer pay for any coverage for any care given to them while in that institution. The institutions were part of the HMO network, and both patients had been admitted to facilities that were part of the approved plan for the HMO. Both of these cases were long term hospitalizations, and they were being moved to a different level of care.

VA Health Quality Center #1: The Virginia Health Quality Center is federally designated and a major part of their work revolves around analyzing quality of care for Medicare. However, we have also looked at these issues for Medicaid, Champus, and other review categories. One of our major responsibilities has been to review specific instances of care given to these types of patients, but more recently we have been looking at broad patterns of care, addressing important issues of quality of care, and trying to improve care. Specific instances regarding (1) the discharge of patients have come to our attention over and over through a contract with Medicaid. Often patients are worried that they are being discharged from the hospital too soon and without comprehensive instructions for follow-up care. More recently, there are rising numbers of complaints in the area of (2) nursing homes. These concerns relate to questions of whether they need a more skilled type of care or whether patients are being referred in a timely way for acute care. There are always complaints regarding (3) specific physicians and hospitals. As you know, the number of patients enrolled in Medicare HMOs is small at this time. We are the people who would review those complaints, independent of the HMO, hospital, or provider. We function as advocates for the patient.

There are other more specific issues that have been mentioned under broader categories, such as

whether patients are afforded options of care for the early stages of breast cancer (breast conservancy therapy vs. mastectomy), appropriateness of the use of cardiac catheterization, and others. We are also conducting on-going studies about the use of anti-coagulant management of human strombosis, peptic ulcer disease, flu immunizations, access to mammography. One project geared directly towards HMOs is looking at the treatment of diabetes and whether patients are having the types of tests they need.

Virginia Department of Health (VDH), Center for Quality Care Services and Consumer Protection #1: To date we have had 32 complaints referred to us from the Bureau of Insurance dealing with HMOs. The largest group of complaints concerns access, in terms of denial of referrals or urgent care. The next largest has to do with provider care. The third group is concerned with pre-authorization, continuity of care, slow response to urgent situations, lack of action on complaints. Examples:

An enrollee diagnosed with an aggressive form of brain cancer was told that this type of tumor could double in size over the course of ten days. The in-network oncologist suggested that he see a doctor who specialized in the growth of tumors, and he was offered a random, computer-chosen treatment. Two different types of treatment were not effective. Through the advice of the oncologist, he found an experimental chemotherapy program at an university hospital. The physician at the university did a craniotomy, and a drug company supplied the experimental chemotherapy at no cost. The HMO denied coverage because the university was not an in-network provider, even though it became one while the enrollee was receiving treatment. The university and the physician both agreed to accept the HMO's usual payment, and still the HMO denied coverage. The enrollee wrote to every known public representative and state agency. Eventually, the HMO did agree to cover the treatment, but the patient went three weeks with no treatment option.

A five month old developmentally delayed baby was referred for treatment of gastro-esophageal reflux. The referral was delayed from February 25 to April 16 before it was approved, a significant amount of time in this child's life. The enrollees complained to their public representative who passed this information to the Center. Blood work for ill children had been delayed at the laboratory because the HMO would not pay for it at the pediatrician's office. The plan requires children to go to an in-network hospital to have the tests. The public representative had received 7 complaints of this type in the last month. This delays treatment for the children.

Another enrollee had surgery delayed because of a lack of surgeons to do the orthopedic procedure. The enrollee was told the surgeons were all on vacation.

An applicant who had been raped in 1989 sought counseling for that episode in 1995. She was denied the opportunity to enroll in an HMO in 1996. She felt she had been a victim twice, because she was doing the appropriate thing to maintain her mental health.

An enrollee complained that an HMO physician diagnosed herpes zoster (shingles) as acne. The HMO took no action about that complaint.

Several enrollees have complained because the HMO does not respond appropriately to emergency situations.

Several enrollees complained that HMOs do not cover breast reconstruction, but instead offer prostheses. This is of great concern to the patients, particularly in relation to their mental

health.

A provider complained that the HMO would not cover any laparoscopy or hysteroscopy that he performed because the HMO utilization review had determined that the procedures had been used inappropriately on two other enrollees.

Complaint Process

Study Group Member: (to VDH, Center for Quality Health Care Services and Consumer Protection) What do you do when you get these complaints?

VDH, Center for Quality Health Services and Consumer Protection #1: We talk to the complainant and provider to get all of the details and urge the patient to go through their HMO's grievance process. Then we write to the HMO and ask if they have an explanation. We try to get information from all of the parties involved.

Study Group Member: How many employees do you have investigating these claims?

VDH, Center for Quality Health Services and Consumer Protection: We have one new employee who will be devoted solely to this. We have a total of 6 employees who deal with these claims.

Study Group Member: Over what time period did you receive these complaints?

VDH, Center for Quality Health Services and Consumer Protection: The majority of complaints have come in the last 2-3 months. We've been tracking them for the past year.

Study Group Member: What have you done to ensure confidentiality? When you pass that complaint along to an HMO, have you used a waiver form from the complainant to discuss that particular case?

VDH, Center for Quality Health Services and Consumer Protection #1: We do speak to the complainant in every single instance, if we are able to reach them.

Study Group Member: That piece of the process is critical. If an HMO were to get a notice from you, and you did not advise the HMO that you had a waiver regarding confidentiality, that could delay the process.

VDH, Center for Quality Health Services and Consumer Protection #1: We also accept anonymous complaints.

Study Group Member: That's fine, but if you want some resolution to the case...

Study Group Member: There is a new confidentiality waiver form for patients from the Health Department.

Study Group Member: I believe the Medical Society sent out a form to all of the physicians. It was from the Bureau and the Housing Department. They asked that it be placed in the physicians' offices so that patients could get them and file complaints.

Complaint Remedy

Study Group Member: What is the remedy when the Health Department has found a problem in the

quality of health care? What do you do?

VDH, Center for Quality Health Services and Consumer Protection #2: Right now, the Department of Health does not have its own regulations. We are currently functioning under the State Corporation Commission. If there should be a remedy, the Department of Health would recommend it to the State Corporation Commission and the Bureau of Insurance. They can impose penalties.

Study Group Member: Part of what we are doing in the context of HB 2785 would be considering whether additional regulations are needed.

Study Group Member: Of the 32 complaints that you have received, have any been referred to the Bureau of Insurance?

VDH, Center for Quality Health Services and Consumer Protection #1: Many of them were referred to us from the Bureau of Insurance.

Study Group Member: Have you sent any of them back to see if any action should be taken?

VDH, Center for Quality Health Services and Consumer Protection #1: We have copied many of them and sent them back, but that resolution is not always satisfactory to any of the parties involved.

Study Group Member: (to the Bureau of Insurance) Once you get them, what do you do?

Bureau of Insurance: As far as I know, if there has been an quality of care issue, the statute does not give us any authority to impose penalties.

Study Group Member: There are different points in the process that different departments can receive complaints, but ultimately, they make it to the Center for Quality Health Services. Once it has been to the Bureau of Insurance, then the Virginia Department of Health will look at it. If it is a provider complaint it should be referred to the Department of Health Professions. We have to look at that process, and whether it is consumer friendly. If a complaint came to the Department of Health Professions that was not a complaint directly against a physician, the SCC - Bureau of Insurance would make a referral to the Center for Quality Health Services. After all of that has happened, you have a resolution. The next question is, is there a log that is kept? Is there some way that this loop knows that the loop has been closed?

Department of Health #1: There is a log kept at the Center for Quality Health Services and Consumer Protection, and the Bureau of Insurance has a fairly sophisticated data bank with contract issues. At the end, the complaint will go into the HMO's file. At the time of the Market Conduct Survey, that would be one of the quality indicators we would look at. We would look to see if there is some trend or problem with the system.

VA Health Quality Center #2: We are here to figure out this process for the State, but it might help to hear what we do at the Virginia Health Quality Center. As a federal contractor for the Health Care Financing Administration, we follow a process whereby we can make a recommendation to the Secretary of Health and Human Services that a facility, physician, or other type of provider be removed from the Medicare program. This has a significant impact on an individual's practice. On a less drastic scale, we can require that physicians or providers do educational work, ranging from attending courses to being overseen when completing certain tasks to engaging in fellowships or preceptorships under experienced

physicians. We profile these facilities and physicians over time so we can see if these complaints continue to occur. If the pattern continues, then we can sanction the facility or provider. VA Health Quality representative #1 is more involved in this, so she can add to what I am saying.

VA Health Quality Center #1: Our sanction authority allows us to recommend to the Secretary of Health and Human Services that a physician be excluded after a very comprehensive review process that includes an appeals level with a panel of physicians and other health care providers who meet with the provider. We discuss the nature and root of the problem thoroughly, as well as what could be corrected so that it will not happen again. In that process, we address correct actions or improvement plans. We look at whether there could be a change of protocol at the level of the provider or facility or whether the problem requires a remedial response, such as education or retraining on a certain procedure. There is a broad range of intermediary actions that we take with providers to make sure that this type of problem does not happen again.

Rash & Associates: Can you explain what a Market Conduct Study is? I hear that term a lot from the insurance companies. Are you looking at the marketing material, such as things that are misleading? Or are you looking at the quality issues?

Bureau of Insurance: The Market Conduct Study looks at anything the laws govern. That includes the marketing information and claim payments. We do not have medical people, so we cannot look at quality of care issues.

VDH, Center for Quality Health Care Services and Consumer Protection #2: That is the purpose of MOU with the Department of Health. We physically go with the Bureau of Insurance during their Market Conduct Surveys and look at quality issues such as access, availability, provider credentials, the Quality Assurance Plan, what kind of services they are providing, quality of providers, and all of the complaints that the plan has received.

Study Group Member: As part of this study, we are trying to describe the complaint and grievance process. We have written a document that is currently being reviewed by the different agencies that discusses the statutory and regulatory details. Maybe we should make a simple flow chart for a complaint as it goes from beginning to end, so we can get the big picture.

Study Group Member: I just wanted to comment on the subject of remedies for complaints. VDH, Center for Quality Health Care Services and Consumer Protection #2 has pointed out that through the Market Conduct Surveys, which the Commissioner had the authority to do before the statutory change but elected not to, one of the remedies is monetary sanction or fines for the HMO. Other remedies through statute are found in the HMO Statute itself, which speaks to the revocation or suspension of licenses based on a finding by the Commissioner of Health. There are about seven or eight different types of findings, which are all related to the issue of quality of care, access, and failure to insure benefits for the enrollee. You have the possibility for monetary fines through the Market Conduct Survey as well as statutory authority for suspension or revocation of the license.

VDH, Center for Quality Health Care Services and Consumer Protection #1: I just want to be clear that we have 23 categories that we certify for the federal government. When we find that there is a problem with a provider or hospital our files are open to the public.

AARP: As this conversation has bounced around from this Bureau of That to the other, think of the poor consumer on the street. On a different subject, I have traveled around the Commonwealth and the country on behalf of AARP. I think all Medicare programs should be held to the same regulations that all HMOs are held to. From an access point of view, the issue is choice. Do I have a choice about HMO, about providers, etc.? There is also a big concern about pharmacy formularies. The Secretary of Health and Human Resources has a study on anti-drug switching. Yesterday's *Wall Street Journal* had an article about HMOs. The point is that there is a perception of problems with HMOs. This may never reach the actual formal complaint process. Whatever comes out of this study is going to have to be salable to the general public so that they can have confidence in the system.

Facilitator Dr. Dukes asked the group to consider questions two and three. He asked that the patients and advocates speak first.

- 2. Are HMO enrollees provided with the kind of information that allows them to successfully understand and access HMO's complaint/grievance/appeals systems?*
- 3. What have purchasers and consumer advocacy groups done to inform patients and consumers of existing appeal and complaint mechanisms?*

Consumer Use of the Complaint Process

Consolidated Coalition for Quality Health Care: The comment made by AARP indicates that consumers' concerns go beyond the grievance and appeals process. In fact, we should look at these grievances and appeals as testimony to the failure of our health care system. We should be dealing with this from a regulatory point of view, through licensing standards, and a monitoring program, information for consumers. We need to build a kind of delivery system, which is the aim of all of us here, that preempts these kinds of complaints. The discussion today deals almost entirely with the grievance process, yet I think the Study Group is entitled to make recommendations about licensing standards, the need for on-going quality monitoring, and the need for detailed information for consumers so they can navigate the system.

It is foolish to believe that the only time a consumer has an interest in the health care system is when they have a serious complaint. In fact, there will be very few serious complaints about this, and yet there is lots of confusion and concern about it. What you are hearing from the advocates sitting around the table is that we do have to work on the process for grievance and appeals, but we also have to work on licensing standards and a monitoring system that works on a population basis to ensure that the HMO is referring people appropriately to specialists, is admitting people to hospitals when they should, etc. That's not something that individuals can monitor. I hope today or at some future point, we can expand the discussion to the full range of quality protections and quality accountability systems that are needed. I do think that this issue extends beyond the grievance and appeals subject.

Study Group Member: I understand what you are saying, but a couple of points are necessary to

understand as well. The study was only given five months. What you've outlined, when we were in the Federal Government would have been a 2 year, \$2 million Rand Corporation Study. Secondly, right now, on-site examinations are taking place at HMOs. Perhaps we should look at more frequent examinations. Right now, if nothing were to change there are about 6 HMOs per year visited to review their quality of care plans. This process of on-site examinations should hopefully identify some of the problems you are discussing. We are gathering information so we can look at this in an impartial and objective way.

Consolidated Coalition for Quality Health Care: I understand that. We also need to look at what is actually on the books, like the standards that are used by Conduct Market Surveys, to make sure that appropriate standards exist. A lot of issues came up this morning about whether there are appropriate expectations for plans on such issues as continuation of provider services when there is a termination of the plan, a standing referral to a specialist when an individual has a chronic condition, appropriate marketing guidelines to make sure that enrollees understand exactly what their rights are when they enroll and know the incentive structure of the plan for the individual doctor, that they have a choice of a primary care physician, and that the patient can go to an emergency room when he/she believes that their health is in danger. Part of the evaluation has to be not only the substance of the market survey, but also an evaluation of whether the appropriate statutory expectations and standards are in place so that the licensing oversight can be appropriate, so we can build in quality and consumer protection and never get to the point in time when we are sitting around the table talking about consumer complaints and appeals. That is a failure of the system. We need to build protection in.

Rash & Associates: Typically the information that enrollees get from the plans is what is called an "Evidence of Coverage Book." In that booklet, the grievance procedure is outlined, but that is only for the plan that they are enrolled in. Many times people are completely unaware of other opportunities for assistance through the Bureau of Insurance or the Department of Health or even through advocates. It is very easy for the process to disconnect because there are so many threads. The issues involve the patient (employee and member of family), the employers, the providers, the insurance company, marketing, finance, attorneys. It is very confusing and very easy to get disconnected.

Consumer Information and Education

Patient Advocate Foundation #1: (endorses Consolidated Coalition for Quality Health Care remarks)
The HMO industry is requiring the consumer to become an informed and responsible consumer. However, today you have heard cases of patients who have become informed and have tried to work within the system and follow the rules. You have heard about people such as Patient #1, who have been fighting this battle for over a year. If there is anything you can do to improve the system for the industry and the consumer, it should be that the documents received by enrollees include all of the information they are going to need to be informed consumers. Provide them with the approved formulary, and when there is a revision made to the formulary, provide the revision. Provide them with a list of usual and customary charges, so they can understand what their responsibility is. Help them understand what the list of providers means to them, in terms of their choice of primary physicians, specialists, and institutions to which they can be referred for care. I am convinced that if you provide the consumer with that kind of information up front, that they will be good consumers and play by the rules that have been established by the managed care industry. But at this point they are being placed in the arenas of managed care without that information. They are getting caught up in an appeals and grievances system often because they never understood the rules to start with. The most important thing you could do is tell

the HMO industry to provide this information to the consumers.

Study Group Member: This is an overwhelming task, but I am not sure that the sole responsibility falls to the HMO. There are employers, providers, and at some point, we the consumer have to assume some responsibility. I don't know how that will be formalized into a structure. We, as consumers, might be confused now, but we are not just victims. A question goes to the advocates; what are you doing to educate your patients about what they need to do to "navigate" through the HMO, and what sort of systematic surveys or other efforts are you involved in?

Patient #5: The Virginia Mental Health Consumers Association in conjunction with the Virginia Alliance for the Mentally Ill conducted a survey recently about HMOs. Someone at Harvard University studied managed care and found that access to information was lacking. Medicaid is doing a better job now at providing information. BMPA is planning to hold a town forum to help patients become better informed. We are only one small piece of the pie. There are many groups out there who are collecting information and conducting surveys, but it is not tied together in any systematic way. We hope that there will be some way to help patients, who, even with a book that tells them what they need to do, can't navigate the system. The Study Group has a chance to create a system to help patients, so they don't end up in the grievance process.

Department of Health #2: When patients are looking for help in a state agency, they often want help for their own specific problem. We can't look at the issue at that level, so what you (the advocates) are proposing is very valid.

The facilitator asked if there were any other advocates who would like to respond to the question of education.

VA Farm Bureau: Over the course of the past 23 years, we have seen an evolution in the health care industry. In the 1970's we were selling full-service coverage. Now we are beginning to see more concern about the costs, and HMO policies are the fastest growing block that we sell. The consumers are attracted to HMOs for a reason. I think that there is a lack of education in knowing the right person to contact. Subscribers can all tell me exactly how much they pay every month, but they can't tell me what product they have or the coverage they have. I am guilty of that myself. I have pushed the responsibility of knowing all the benefits that I have off on my employer. But these are real problems. We are looking for that easy solution, and I really don't think there is one. The consumer has to accept the responsibility, and I don't know how we can educate them. Fortunately, I don't hear the horror stories like we've heard here today.

Independent Appeals

AARP: We do not deal with individuals. Our programs are more general. We do have materials about managed care in general, consumer protection in managed care, and basically what a potential enrollee should look for. I would answer question #2, about whether enrollees are provided with enough information to understand the HMO system, that they clearly are not. Even in HB 2785 it says that HMO publications must provide information in clear English. That law goes into effect July 1, but are we not

in effect saying that there does need to be a clearer understanding? Also, at the time an individual patient has a problem, is the HMO helping them, telling them how the process works? No, instead you have to go around the barn trying to find a way to access the process. Also, in the interest of fairness to everyone, there must be another step in the process, that is, an independent review with authority. Maybe the VDH can do it as part of another process. As long as they have the authority to follow up on the decision.

Study Group Member: I wanted to respond to AARP's suggestion for an external, independent appeals process. As I understand it, an independent review process would be something like arbitration where an independent person who isn't familiar with the case will be asked to decide the case based on the merits of the facts as presented. Maybe I have mis-represented it, but that is typically what I hear, when I hear about independent appeals. Is this really what patients and advocates want? I wonder whether an independent appeals process is really an appropriate fix. It strikes me that it is going to be pretty removed from the patient's situation. The decision will need to balance the disputing perspectives and cast a judgment, which will be final.

The facilitator asked the group to go around the room to give final comments and any responses to this characterization of an independent appeals process.

Closing Comments

Patient Advocate Foundation #1: California has just enacted, effective September 1997, legislation describing an independent appeals process. The appeals and grievances system had become very muddled as the HMOs tried to deal with the volume of concerns. The patient population felt there wasn't a fair appeals process, and by the same token, the HMOs felt they were also being victimized by the process. They've enacted legislation that describes very specifically the membership of the appeals panel. The California Department of Health has input into the members of the panel. There must be members of the provider community from the specific area of specialization in question. That legislation passed with no dissenting votes and with the full support of the HMOs. Anytime we can effect a reform that has the support of the managed care industry and the support of the patient population, perhaps we are beginning to get some answers. We can provide this to you, and it's on our website.

In terms of what we are doing to inform and educate, my experience is that we and other advocacy groups are trying to put information out there that will inform the consumer. I agree that we need to unite. I just returned from a meeting in Colorado of advocacy groups. We agreed to link our websites, so that readers can immediately access all the other information from all of the other consumer groups across the country. We've also published a book, *The Advantage Care Answer Guide*, which will be posted on our website as well. So we really are making an effort to educate and help consumers. We offer the opportunity for patients to interact with attorneys or with a case manager who practices case management with HMOs everyday to get their questions answered by a human being, one-on-one.

Patient #1: How many around the table belong to an HMO? (most) So you know the types of problems that people have, and sometimes you voice them and sometimes you don't. As a consumer, I know that

you officials don't hear 80% of the complaints. People don't know about the appeals process because 80% of the people out there aren't on the Internet and don't even own a computer. It's great for those who own a computer, but not for those who don't have one or aren't on the Internet. You are offering help to the smallest portion of the consumers.

The problem with HMOs is that they have built in deterrents to treatment. These deterrents are in the form of a co-payment or in the form of allowing a doctor to have 300 patients instead of 200 so you have a 3-hour wait in a doctors office and don't make an appointment. You stay home when you have the flu and take care of it. Your HMO makes money even if you don't go because you pay them every month. They say that you can have 20 visits for mental health, but you have to pay \$25 a visit. What most people don't think about is that in a catastrophic situation, it's not just one person who needs help. My wife and I need help. That's \$50 a month! I'm already bankrupt and in foreclosure on my house because of what's going on. I don't have \$50 a month, so I'm not going to get treatment. It sucks!

Consolidated Coalition for Quality Health Care: This is an emotional issue and it demonstrates that all health care is personal, ultimately. However, the other side of the story is that managed care, if done right, can accelerate the quality of the healing process. This can be accomplished through building an integrated patient-centered, consumer-centered, delivery system that is accountable for improving the health care status of enrollees. That is a wonderful and possible vision. Today and everyday, we are hearing that the industry is not living up to that vision. They're in a better position to live up to it than the fee-for-service delivery system was. In that system, you have physicians in isolation with no accountability and no peer review. I have seen rural doctors who were loved by their patients but practicing 1950's medicine. We need to recognize, and I think consumers do recognize, that managed care is here to stay. The challenge is how to make it work for consumers. With that as our goal, integrated, consumer-centered, accountable delivery systems need to be put into place to give consumers the confidence that managed care is reaching that vision. This is not simply developing an elaborate financing scheme to give incentives to providers to provide less care to consumers. We are hearing that often firms take financial risk, pass it on to consumers, and then walk away from building an integrated delivery system.

What do we need?

Licensing standards: I would urge the study group to look at the licensing standards for HMOs in Virginia to make sure that they each meet the challenge of having the best practice standards in place, that they meet the minimum standards we should set for any HMO. This relates to a comprehensive provider network, prudent lay person emergency service, internal grievance appeals, and the other basics that we should expect from every HMO.

Consumer information: Consumers need to have information as enrollees. They need to understand the appeals and grievance mechanism, their benefits, utilization management, and how they get to see a specialist. They also need information to help them choose an HMO, such as information about quality performance on a comparative basis. Many consumers don't even have a choice of a health care plan. Their employer picks the plan for them. One of the things the state could think about is how to expand consumer choice. If you had choice, and people were picking not on the basis of the lowest premium cost but on who is achieving the best results for patients, we could provide some competition in the market place based on quality not cost. Often employers do go with the lowest cost, no offense meant to the employers sitting around the table.

Comprehensive population-based monitoring system: This should focus on the primary issue concerning HMOs, namely access to care. We have data and technology now that would allow the state to routinely monitor the utilization rates of plans to make sure that people are getting appropriate referrals to specialists, that hospitalization rates are what they should be, etc. This can build a system in which we can be sure that quality of care is there and that we are improving quality of care.

External appeals system: I would endorse an independent appeals process. I think Dr. Daniels was describing the Administrative Law Process, which is the ultimate appeal to the state. There could be an intermediary external appeal, like we have in the Medicare program, which is a smart group of independent practitioners who independently investigate the case and render a professional, medical opinion on it. That process can be expedited and quick, but the basic principle is that it is independent of the plaintiff. If the reconsideration process is within the plan, then the plan is judge and jury.

Knowledge of appeals system at the time of denial of care: When an individual is denied services or services are reduced or terminated, they need written notice that there has been denial of a service, and at that moment, they need to be informed of what the appeals process is. That is when they need the information to act on. You forget it when you are enrolling, but you need it then. I think that this is a very exciting journey. Our job here is not to come and criticize managed care. Managed care can be an exciting advance for patient health care. Good managed care plans do exist, but we've got to figure out a way to make sure that all plans are being held to appropriate standards.

AARP: The previous comments sum up everything that I was going to say, but I want to follow up on the computers. Most of the people who are going to be at the critical point of needing help with the appeals process are likely to be frail, elderly, indigent, or poor. They don't have computers, so don't forget the written word as a way of educating and informing consumers.

Department of Health Professions #2: I feel good that I have heard all of the problems that I came with mentioned during this meeting. As a complaint analyst with the DHP, I hear all kinds of complaints. One of the things that we have to do is help people sort out who the complaint is really about. That is not always easy. If the patient has a complaint about the quality of care received from their provider, how much of this complaint can be attributed to the HMO? One more thing is that recently we have seen more complaints from providers who are concerned about the quality of the utilization reviewers. These complaints are becoming rather vehement. We also get the impression that consumers believe that HMOs are somehow endorsing the providers on their listing. Consumers are expecting an on-going screening and evaluation of providers.

Medical Society of Virginia: Those consumers who have some knowledge and can push seem to get results. Unfortunately, the vast majority of consumers are not able to do that, and that majority is going to increase. Especially now that the Medicare population is being moved into HMOs, advocacy will be very important for these individuals, who frequently have difficulty getting through any kind of system. I don't know how we can make it any easier.

VA Power: The issues raised here are coming from a lot of different sources and are very dynamic. It is very important to try to look at this in a systematic and logical way. The individual cases are very important, but also, the group should try to get at the heart of other issues that are very prevalent. These issues should be prioritized so that the group can deal with them effectively within the time and resource constraints. It is difficult to unravel so many issues at once. I would also like to add that employers are concerned about quality. We look at networks and the credentials of providers.

VA Farm Bureau: We need to educate consumers about the difference between HMOs. We, as employers, have that responsibility. There are a lot of good service vehicles out there, and the Bureau does a good job at monitoring problems. I don't think there are any quick solutions to this issue, and I don't envy your job.

VA Health Quality Center #2: An independent, third-party complaint process is anything but a cold, heartless process. People call us because they have tried to work it out with the HMO but they can't get through to the insurance companies or don't get a response. They also call because it's toll-free. People are very angry when they call our organization, and we get very familiar with the people and their problems. There are significant benefits to the process. Also, we have been talking about a chicken/ egg situation. Is it better to improve the system so that we don't have the problems and complaints, or improve the system to deal with the complaints? In the same argument, we can either prevent crime and prevent problems from happening, or we can pay the price by building more jails. We need to prevent the complaints from surfacing at all.

Patient #5: I have concerns about people saying that the responsibility lies with the patients. I know a Medical Director who didn't know what to do. We need to help everyone become partners in health care through patient education AND provider education. I hope the Study Group does not put any more money into grievance procedures but focuses on avoiding grievances down the road. They need to put money and ideas into bringing people together so that we can become partners in health care, and so that people can be educated and work better together.

Benova: We function as an enrollment broker for Medicaid. We try to both enroll and educate. Medicaid is changing, and people are just receiving letters saying that they have to enroll in an HMO or one will be chosen for them with no explanation. People call up saying that they just want to be on "normal Medicaid." We need to educate people about the process and focus on the preventative. We need to help the consumer know that the doctor can refer them to a specialist and all of the other things that we have been talking about during this meeting.

VA Health Quality Center #1: I would like to make a plea for simplicity. The system is complicated and fragmented, we don't need to add more complications. The argument for an independent review is very appealing. Often patients are concerned that they will not receive good care because they have complained. Also, through an independent and centralized system, the state could track trends and look at patterns of problems. The review system could also be expanded to be responsible for tracking, monitoring, and for developing mechanisms for improvement.

VA Department of Personnel and Training: One of the most compelling issues that we deal with that often does not reach the appeals level, is the help that people need when they are transitioning from one level of care to another, such as a transition to home care. We need better definitions of what is allowable. People go home not knowing how they are going to care for themselves. This type of thing must come from the providers. Providers call us about these problems because right now, the appeals must be filed by physicians. More obvious problems usually get solved. It is the more subtle problems that are not so easily solved.

Rash & Associates: One of the most important issues is communication. The biggest problem is not understanding the rules. Employers and purchase consultants must communicate those rules to the consumers. One practical solution is inviting spouses to the informational meetings. At the risk of sounding sexist, often the health of a family is overseen by the wife, who rarely gets to hear an

explanation of the plan. This type of communication does not require regulation so much as it requires common sense.

People want choice. Employers should offer both HMO and point of service plans, so the employee can choose the most appropriate plan.

In the referral process, the “gate keeper” should be skipped. Patients should be able to see specialists, as they need them. There are good plans, and hopefully, the mediocre plans will fall by the wayside as the health care evolution continues.

Often there is a disconnect from the providers. I have seen an underlying resentment towards HMOs, and that is surfacing in the form of “disinformation” from providers to patients. They make the HMO look like the bad guy. The patient is squeezed in the middle, and they get nervous. To create a partnership in health care, the communication must start with the providers. Patients expect providers to take care of all of the paperwork and expect everything to be done for them, but they must be made to realize that they too have a responsibility and be helped to understand what that responsibility is.

One more very important suggestion deals with the denial of claims. The consumer must know immediately that the claim has been denied, not two weeks later. People get frustrated when they have to wait to hear that they have been denied a form of health care that they felt they needed.

Dr. David Buchsbaum, Medical Director for Aetna US Health Care Virginia: During this discussion I have been thinking about our own policies and procedures for dealing with managed care. I am gratified to know that this conversation is going on. No more than 20 years ago, health care was a private affair between a doctor and a patient behind closed doors. Now we are making physicians accountable to the citizens of the Commonwealth. Our company is devoting an enormous amount of time to quality and enforcing accreditation rules. I think we are evolving, and we do listen. This is a dynamic process, so consumers, providers, HMOs, and the state are coming together to move forward through the process together.

Patient Advocate Foundation #2: We have heard some frightening stories about barriers to care and restrictions. I want to look at the broader picture of potential solutions to these barriers and restrictions. We could get out our band-aids, we could get out bigger regulatory sticks, but these would be short-term solutions. We need to seriously consider the structure of the system, particularly minimum expectations. We also need to help employers know what kinds of information they need to provide and help consumers know how to use the system. The system has to be improved overall. There should be recommendations about a new, overall structure for the system.

Dr. Daniels concluded the Roundtable, thanking the participants for their time and contributions.

A summary of the Roundtable session will be posted in June at the website address:
<http://www.vdh.state.va.us>.

The following letters were received from interested parties and are included as part of the summary of the Focused Roundtable for Consumers:

PATIENT ADVOCATE FOUNDATION
A National Network for Healthcare Reform
739 Thimble Shoals Boulevard, Suite 704
Newport News, VA 23606
Tel: 757-873-6668; Fax: 757-873-8999; E-Mail: ndepaf@pinn.net

May 22, 1997

RE: Meeting with HB2785 Study Group

TO: Committee Members

FROM: Nancy Davenport-Ennis
Founding Executive Director

Thank you for your investment of time, energy and expertise in examining issues relative to ERISA plans in which the employer pays health care claims directly, although an insurer or HMO may be retained to administer the plan and disburse the claims payments.

Our experience reflects the following as factual:

1. Capitol Care of Northern Virginia makes arbitrary and capricious reviews of cases that involve both quality of care issues and access issues. Two patients who have been represented by our attorneys have had Capitol Care cut off all coverage for their medical services while they were hospitalized with medical emergencies. One patient, a thirty-five year old male, was forced by Capitol Care to be moved from one treatment facility to a distant facility. The treating physician warned Capitol Care that this move could be fatal to the patient. The Capitol Care representative insisted upon the relocation of this patient. The patient died upon arrival at the distant location.
2. G.W. Health Plan of Washington, DC does not approve primary care given referrals to specialized care routinely and the result is loss of life. If a referral is approved, which is seldom, the patient is directed to carve-out specialists which historically mean geographical relocation. Experience reflects that a high percentage of those referred to distant locations do not accept due to increased hardship on their family financially and personally. Further, this company routinely denies care until the patient's condition reaches a stage that does not allow for them to be treated.
3. Cigna Healthcare of Virginia manages the ERISA program for the hourly workers at Newport News Shipbuilding. See the attached BROWN case for an example for which therapy is being denied to a newborn girl who suffered oxygen deprivation during birth based on TRIGON's

interpretation that they do not cover developmental therapy: they only cover rehabilitative. They have determined that this child's therapy is developmental. In the 1997 General Assembly, House Bill No. 2716 has been passed into law requiring insurers to provide coverage for "early intervention services including medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act. Medically necessary early intervention services for the population certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services shall mean those services designed to help an individual attain or retain the capability to function age appropriately within his environment, and shall include services which enhance functional ability without effecting a cure." This legislation goes on to state "there shall be no denial of coverage due to the existence of a pre-existing condition." With this law in place, we made an appeal to the employer to review this case with the HMO managing their ERISA plan. No revision in coverage has been made for this child.

4. Prudential Health Care Plan of the Mid-Atlantic has also been cited as refusing coverage for Autologous Peripheral Stem Cell Transplant on the grounds of "medically necessary." Plan language states "care is considered medically necessary when it is accepted by the health care profession as appropriate and effective . . . and it is not experimental and investigational." Certainly legislative bodies in ten states would refute this language, including Virginia, as would the federal government 1994 OPM mandate covering federal employees.
5. TRIGON Blue Cross Blue Shield denies Autologous bone marrow transplantation for Waldenstrom's Macroglobulinemic citing it is not covered in the patient's benefit program. Our experience reflects that the ERISA plan relies upon the direction of its management entity for references of what coverage benefits to include in their employees plan language.
6. TRIGON Blue Cross Blue Shield denies ABMT for ovarian cancer stage III for 35 year old patient due to "service is not included in plan benefit." The employer and plan manager determines what is in the plan benefit.

As long as ERISA plans are exempt from the laws of both states and the federal government that define coverage criteria and expectations for consumer protection and minimum standards required to offer benefits that reflect integrity and continuity, citizens will continue to experience rationed healthcare, redirection to distant service providers, random, capricious and arbitrary coverage decisions and continued denials based on conflicting policy language. The primary example of conflict of interest is policy language that states "medically necessary" services will be covered only later to be excluded in specific exclusion language defined by the plan.

Reform of ERISA requirements is required to define integrity in self-funded plan management.

**PERMA TREAT
PEST AND TERMITE CONTROL**

22 May 1997

Ms. Alison Croke
Department of Health
Fax: 804-371-0116

Dear Ms. Croke:

I regret that I will be unable to attend the focus group session tomorrow to discuss H.2785.

I am the owner of PermaTreat Pest Control, serving fourteen counties in the Northern Virginia area, with sixty employees. In 1987, PermaTreat was named Virginia's Small Business of the Year by the U.S. Small Business Administration.

I am vice-chairman of the board for MediCorp Health System and past chairman of the board for Mary Washington Hospital. I feel that I have a well-rounded view of health insurance issues from three directions . . . the employer, the provider, and as an employee, since I and my family are members of an HMO. I provide health insurance to my employees and their families, and I have the following observations to make:

Competition in the insurer/provider field has been intense and, overall, has worked very well to help reduce insurance costs to employers. At one time, I was considering dropping group insurance for employees because the cost was becoming astronomical. Blue Cross/Blue Shield hit me with a 43% rate increase in one year. Competition has brought the rates back in line and our increases seem to be confined to single digits, which is bearable.

Government should stay out of health care as much as possible at this point and let the market adjust itself. Most of the problems involving insurance will probably solve themselves over a period of time.

Almost all plans offer the choice between the HMO approach and the traditional point-of-service plan. If my employees are unhappy with the panel of providers presented by our HMO, then they can opt to take the point-of-service plan and see any doctor they wish. This approach costs a few dollars more - \$5 or \$10 per month more.

Providers dislike HMOs for obvious reasons. Some employees may complain because they cannot see the doctors they want under their HMO plan, but they certainly don't complain about the savings in premiums.

I firmly believe that, over a period of time, we will all get used to the system and we will all save money. Personally, I am extremely pleased that I am able to continue to provide health benefits to my employees without having to pass on a larger and larger portion of the premium.

Thank you for the opportunity to express my points of view.

Sincerely,

PERMATREAT, INC.

Joe R. Wilson
President